



Wilma L. West Library Resource Notes

Domestic Violence

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Specific references to child or elder abuse are not included in today's Resource Note (RN), as they will be addressed individually in future Notes.

As I was beginning to pull together sources for today's Note, the new booklet describing the Center for Outcomes Research and Education (CORE) in the Department of Occupational Therapy at the University of Illinois in Chicago (UIC) was dropped on my desk. In it, I found a description about the work of Christine Helfrich, PhD, OTR on domestic violence. With funding from NIDRR, Dr. Helfrich is ". . . examining how domestic violence impacts occupational functioning through three interrelated investigations that will document functional problems and identify the need for services among women who are domestic violence victims." There is also a brief mention of a coming paper in which she ". . . compares women who are victims of domestic violence with a national sample demonstrating that the former experience more mental health problems that interfere with their ability to work, attend school and carry out daily living tasks." Dr. Helfrich hopes to use the results of her studies to show the effectiveness of occupational therapy intervention with the victims of domestic violence. Finally, she and several collaborators authored the 2001 book *Domestic violence across the lifespan: The role of occupational therapy*, published by Haworth Press, Inc. It is volume 16, Numbers 2 and three of the periodical *Occupational Therapy in Mental Health*. Unfortunately, I discovered that the library's copy has not arrived.

Following are resources, printed and electronic on domestic violence.

References:

1. Beatt, R.M. (2000). Health professionals' knowledge of women's health care. *Journal of Continuing Education in Nursing*, 31(6), 275-9.

ABSTRACT: Until 1986, the only issues in women's health which received direct attention were those related to childbearing. At that time the National Institutes of Health made inclusion of women in research criteria for funding. Since then, the knowledge base to guide disease prevention and treatment of women has grown dramatically. Unfortunately, the incorporation of these data into clinical practice has been much slower. The purpose of this needs assessment was to establish a comprehensive database on which future programming decisions could be based. Areas of interest identified by health care providers included stress reduction, breast health, prevention of heart disease, and osteoporosis. Other topics that emerged were menopause and reproduction issues, cancer prevention, domestic violence, substance abuse, nutrition, and weight control. These data suggest topics for future programming.

2. Bradley, F., Smith, M., Long, J & O'Dowd, T. (2002). **Reported frequency of domestic violence: cross sectional survey of women attending general practice.** *BMJ*, 324(7332), 271.

ABSTRACT: Objectives: To determine exposure to violence by a partner or spouse among women attending general practice and its association with respondents' demographic and personal characteristics; frequency of inquiry about violence by general practitioners; and women's views on routine questioning about domestic violence by general practitioners. Design: Cross sectional, self administered, anonymous survey. Setting: 22 volunteer Irish general practices. Participants: 1871 women attending general practice. Main outcome measures: Proportion who had experienced domestic violence, severity of such violence, and context in which violence occurred. Results: Of the 1692 women who had ever had a sexual relationship, 651 (39%, 95% confidence interval 36% to 41%) had experienced violent behavior by a partner. 78/651 (12%) women reported that their doctor had asked about domestic violence. 298/651 (46%, 42% to 50%) women had been injured, 60 (20%) of whom reported that their doctor had asked about domestic violence. 1304/1692 (77%, 77% to 80%) were in favor of routine inquiry about domestic violence by their usual general practitioner. 1170 women (69%) reported controlling behavior by their partner and 475 (28%) reported feeling afraid of their previous or current partner. Women who reported domestic violence were 32 times more likely to be afraid of their partner than women who did not report such violence. Conclusions: Almost two fifths of women had experienced domestic violence but few recalled being asked about it. Most women favored routine questioning by their practitioner about such violence. Asking women about fear of their partner and controlling behavior may be a useful way of identifying those who have experienced domestic violence. Retrieve Full-text:

3. Dubnova, I. & Joss, D.M. (1997). Women and domestic violence: global dimensions, health consequences and intervention strategies. *Work: A Journal of Prevention, Assessment & Rehabilitation*, 9(1), 79-88.

ABSTRACT: Domestic violence against women is a significant health and social problem affecting virtually all societies. The sensitivities and stigma associated with domestic violence, the conceptualization of it primarily as a judicial and legal issue, and the lack of data on the dimensions of abuse have hampered understanding and the development of appropriate interventions. Secrecy, insufficient evidence, and social and legal barriers continue to make it difficult to acquire data on domestic violence against women. This paper describes the magnitude and health consequences of domestic violence. It explores factors that perpetuate violence against women, and discusses intervention strategies from around the world.

4. Elliott, L., Nerney, M., Jones, T. & Friedmann, P.D. (2002). Barriers to screening for domestic violence. *Journal of General Internal Medicine*, 17(2), 112-6.

ABSTRACT: CONTEXT: Domestic violence has an estimated 30% lifetime prevalence among women, yet physicians detect as few as 1 in 20 victims of abuse. OBJECTIVE: To identify factors associated with physicians' low screening rates for domestic violence and perceived barriers to screening. DESIGN: Cross-sectional postal survey. PARTICIPANTS: A national systematic sample of 2,400 physicians in 4 specialties likely to initially encounter abused women. The overall response rate was 53%. MAIN OUTCOME MEASURE: Self-reported percentage of female patients screened for domestic violence; logistic models identified factors associated with screening less than 10%. RESULTS: Respondent physicians screened a median of only 10% (interquartile range, 2 to 25) of female patients. Ten percent reported they

never screen for domestic violence; only 6% screen all their patients. Higher screening rates were associated with obstetrics-gynecology specialty (odds ratio [OR], 0.49; 95% confidence interval [CI], 0.31 to 0.78), female gender (OR, 0.51; CI, 0.35 to 0.73), estimated prevalence of domestic violence in the physician's practice (per 10%, OR, 0.72; CI, 0.65 to 0.80), domestic violence training in the last 12 months (OR, 0.46; CI, 0.29 to 0.74) or previously (OR, 0.54; CI, 0.34 to 0.85), and confidence in one's ability to recognize victims (per Likert-scale point, OR, 0.71; CI, 0.58 to 0.87). Lower screening rates were associated with emergency medicine specialty (OR, 1.72; CI, 1.13 to 2.63), agreement that patients would volunteer a history of abuse (per Likert-scale point, OR, 1.60; CI, 1.25 to 2.05), and forgetting to ask about domestic violence (OR, 1.69; CI, 1.42 to 2.02). CONCLUSIONS: Physicians screen few female patients for domestic violence. Further study should address whether domestic violence training can correct misperceptions and improve physician self-confidence in caring for victims and whether the use of specific intervention strategies can enhance screening rates.

5. Fulton, D.R. (2000). Recognition and documentation of domestic violence in the clinical setting *Critical Care Nursing Quarterly*, 23(2), 26-34.

ABSTRACT: Critical care nurses may encounter a victim of domestic violence or abuse when caring for an individual with traumatic injuries. Understanding the injuries that are associated with acts of violence is only the first step. A vital part of the nurse's responsibilities is the precise written documentation of observations, physical assessments, and other factors that may later become vital evidence in a court of law.

6. Helfrich, C. (1997). Domestic violence abuse: Perspectives for OT Educators and practitioners. In: The American Occupational Therapy Association. (1997). Conference Abstracts and Resources. Bethesda, MD: Author, (pp. 189-190)

ABSTRACT: Domestic violence is an international act of physically or emotionally harming another person related by blood, marriage, having a common child or a dating relationship. This includes a person with a disability and their personal assistant. Domestic violence kills over 3,650 women each year and accounts for more injuries than rapes, muggings and automobile accidents combined (Loseke, 1992). Occupational therapists treat women and children with a wide variety of physical and emotional injuries. Many victims will not readily disclose the violence; instead they create fictitious causes for their injuries. Children who have experienced various types of maltreatment suffer from neglect, sexually, physical and emotional abuse. It is important to identify a domestic violence survivor to administer treatment appropriately. Contact with survivors of domestic violence can raise many issues with therapists such as denial, guilt, memories of one's own history of abuse, blame, anger and fear. Most curricula do not include material on the effects and treatment of victims of violence (Qalens, Dickie, Tomlinson, Raynor, Wittman & Kannenberg, 1995). Therapists must be aware of their own attitudes about domestic violence, issues which arise for them during treatment and factual information regarding the cycle of violence in order to be therapeutic (Davis, 1994). The cycle of violence includes: 1) Tension phase which includes arguing, blaming and anger, 2) Battering phase which includes slapping, choking, sexual abuse, threats and use of weapons, 3) Calm Stage which includes denial, gifts, and other tokens of making up. The calm stage decreases over time as the violence increases.

Occupational therapists can be most effective during battering phase when the woman's defenses are decreased and she wants help. She may fear for her life or the safety of her children. At this time referrals to social work, shelters for battered women & children and

helping the interdisciplinary team understand the psychosocial issues she is enduring are important. The solutions to ending domestic violence are complicated. Many different disciplines, the police, and the justice system all need to be involved; however, a common factor is education. Education about domestic violence is needed to decrease myths and increase understanding of reality and one's own beliefs. The media has added to the stigma of domestic violence in recent years through movies, news reports and television. If occupational therapists are to contribute to ending the epidemic of domestic violence we must begin discussing these issues openly in the classroom, on fieldwork and in work settings. It is not possible to absorb the factual and emotional information about abuse in one session. The information needs to be understood and integrated gradually; therefore educators and clinicians need assist students and colleagues in this process.

7. Helton, S.M. & Evans, G.W. (2001). "She looked just like me." A domestic violence learning module. *Issues Mental Health Nursing*, 22(5), 503-16.

ABSTRACT: This paper describes a 22-hour domestic violence learning module that is incorporated into the psychosocial course for seniors in a baccalaureate nursing program. As part of their learning experiences, students attend circuit court, meet with judges, and accompany advocacy workers. Additionally, they attend group therapy sessions with both the victims and perpetrators of abuse. Students keep journals reflecting their thoughts, feelings, and reactions throughout the experiences. Thematic analysis of these journal entries revealed five common themes. Students recognized their encounters in clinical situations as frightening and emotionally difficult, expressed surprise at their reactions to perpetrators, identified with victims, wrestled with issues of good and bad, and reported that stereotypes about victims and perpetrators had been incorrect. Debriefings and support by faculty are important for students throughout the experience.

8. Jewkes, R. (2002). Preventing domestic violence. *BMJ*, 324(7332), 253-4.

9. Merrell, J. (2001). Social support for victims of domestic violence. *Journal of Psychosocial Nursing & Mental Health Services*, 39(11), 30-5, 46-7.

ABSTRACT: Nurses in a variety of settings encounter people whose lives are affected by domestic violence. Case identification, crisis intervention, advocacy, psychoeducation, psychotherapy, case management, and referral networking are tasks that can be performed by nurses with various levels of education. A holistic approach is needed when caring for victims, perpetrators, and witnesses of physical and psychological violence. A variety of disciplines must work together to challenge this multifaceted social dilemma. Nurses can guide clients to useful resources to help battle the tide of violence existing in society today.

10. Richardson, J., Coid, J., Petruckevitch, A., Chung, W.S., Moorey, S. & Feder, G. (2002). **Identifying domestic violence: cross sectional study in primary care.** *BMJ*, 324(7332), 274.

ABSTRACT: Objectives: To measure the prevalence of domestic violence among women attending general practice; test the association between experience of domestic violence and demographic factors; evaluate the extent of recording of domestic violence in records held by general practices; and assess acceptability to women of screening for domestic violence by general practitioners or practice nurses. Design: Self administered questionnaire survey. Review of medical records. Setting: General practices in Hackney, London. Participants: 1207

women (>15 years) attending selected practices. Main outcome measures: Prevalence of domestic violence against women. Association between demographic factors and domestic violence reported in questionnaire. Comparison of recording of domestic violence in medical records with that reported in questionnaire. Attitudes of women towards being questioned about domestic violence by general practitioners or practice nurses. Results: 425/1035 women (41%, 95% confidence interval 38% to 44%) had ever experienced physical violence from a partner or former partner and 160/949 (17%, 14% to 19%) had experienced it within the past year. Pregnancy in the past year was associated with an increased risk of current violence (adjusted odds ratio 2.11, 1.39 to 3.19). Physical violence was recorded in the medical records of 15/90 (17%) women who reported it on the questionnaire. At least 202/1010 (20%) women objected to screening for domestic violence. Conclusions: With the high prevalence of domestic violence, health professionals should maintain a high level of awareness of the possibility of domestic violence, especially affecting pregnant women, but the case for screening is not yet convincing.

11. Schmerzler, A.J., Goldstein, J. & Parkin, K. (2001). Women, spinal cord injury, and domestic violence: A review. *Topics in Spinal Cord Injury Rehabilitation*, 7(1), 37-41.

ABSTRACT: Women represent an underreported segment of the spinal cord injury (SCI) community. A majority of the literature written on SCI deals with its impact from the male point of view. Very few articles acknowledge or address the social problems that women with SCI encounter. This article will address the specific social issue of domestic violence and will offer a number of recommendations for the rehabilitation community.

12. Sethi D., Watts S., Watson J., McCarthy C. & Zwi A. (2001). Experience of 'screening' for domestic violence in women's services. *Journal of Public Health Medicine*, 23(4), 349-50.

13. Stancliff, B.L. (1997). Invisible victims. *OT Practice*, 2(10), 18-21, 23-28.

14. Taft, A., Hegarty, K. & Flood, M. (2001). Are men and women equally violent to intimate partners? *Australian New Zealand Journal of Public Health*, 25(6), 498-500.

ABSTRACT: Violence against women is a significant public health issue. One form of violence against women, intimate partner abuse or domestic violence, is prevalent in Australia. In this article, we summarize the main theoretical and methodological debates informing prevalence research in this area. We explain why studies finding equivalent victimization and perpetration rates between the sexes are conceptually and methodologically flawed and why coercion and control are fundamental to the definition and measurement of partner abuse. We conclude that while male victims of partner abuse certainly exist, male victims of other forms of male violence are more prevalent. A focus on gendered risk of violence in public health policy should target male-to-male public violence and male-to-female intimate partner abuse.

15. U. S. Department of Agriculture, Safety, Health and Employee Welfare Division.

"Domestic violence awareness handbook"

16. Yeager, K. & Seid A. (2002). Primary care and victims of domestic violence. *Primary Care*, 29(1), 125-50.

ABSTRACT: Providing quality health care involves integrating routine inquiry about domestic violence into ongoing clinical practice. This means asking all women patients, and others who may be at risk, about abuse in their lives. Whether or not a woman chooses to use services or leave her partner, our intervention is very important. Some women return to violent partners several times before they feel safe enough to leave, feel they can survive on their own, or can accept that the person they love will not change. Make sure that she has follow-up for her medical problems and appropriate referrals for mental health and substance abuse problems when indicated.

On-Line Resources:

Statistics:

American College of Obstetricians and Gynecologists, "[Interpersonal violence against women throughout the life span](#)"

U. S. Department of Justice, Bureau of Justice Statistics, "[Violence rates among intimate partners differ greatly according to age](#)"

Organizations and Phone Numbers

American Bar Association, Commission on Domestic Violence

National Domestic Violence Hotline *1-800-799-SAFE (7233) 1-800-787-3224 (TDD)*

National Network to End Domestic Violence

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