DOMESTIC VIOLENCE: INTIMATE PARTNER VIOLENCE, ELDER ABUSE AND CHILD ABUSE

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ABSTRACT

Domestic violence is a common and serious problem in society. It involves violence between intimate partners and against vulnerable members of society, such as children and elderly. This study focuses on identifying the causes of domestic violence and the screening tools recommended to address abuse. The role of health teams to early identify and intervene in the setting of domestic violence is integral to reducing its incidence and prevalence, and to save lives.

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This educational activity is credited for 2 hours. Nurses may only claim credit commensurate with the credit awarded for completion of this course activity.

Statement of Learning Need

Nurses as members of the health team need to understand the causes and appropriate screening tools to identify and intervene to support victims of domestic violence. This includes increasing their knowledge to support victims to identify a safety plan and the abuser to reform.

Course Purpose

To provide nurses and health associates knowledge about the causes, screening tools and interventions for domestic violence in intimate partner relationships, children and the elderly.

Target Audience

Advanced Practice Registered Nurses and Registered Nurses

(Interdisciplinary Health Team Members, including Vocational Nurses and Medical Assistants may obtain a *Certificate of Completion*)

Course Author & Planning Team Conflict of Interest Disclosures

Dana Bartlett, RN, BSN, MSN, MA, William S. Cook, PhD,

Douglas Lawrence, MA, Susan DePasquale, MSN, FPMHNP-BC - all have no disclosures

Acknowledgement of Commercial Support:

There is no commercial support for this course.

Activity Review Information:

Reviewed by Susan DePasquale, MSN, FPMHNP-BC

Please take time to complete a self-assessment of knowledge, on page 4, sample questions *before* reading the article.

Opportunity to complete a self-assessment of knowledge learned will be provided at the end of the course.

1. Intimate partner violence can be

a. physical, psychological, or sexual

b. emotional or medical

c. physical only

d. psychological or financial

2. In intimate partner violence the risk of homicide is greatest

a. at the beginning of the relationship

b. if the perpetrator abuses alcohol

c. if there is a significant age difference between partners

d. if the woman tries to, or does leave

3. Elder abuse can be in the form of

a. psychological

b. financial

c. sexual

d. all the above

4. Child abuse should be suspected if

a. a child < 10 years has bruising of the ears or torso

b. a child ≤ 4 years has bruising/injury to the torso, ears, or neck

c. a child ≤ 4 years has a lower limb fracture

d. a child <5 years has a persistent nosebleed

5. Many perpetrators of intimate partner violence, elder abuse, or child abuse

a. have no close relationship to the victim.

b. are women under the age of 40.

c. have a substance abuse problem or a psychiatric disorder.

d. will readily admit that they are violent.

Introduction

Domestic violence is the term that was traditionally used to describe violence that occurred between a husband and wife, and it was typically perceived as men physically assaulting women. But inter-personal violence that happens in the context of relationships is far more complex. It occurs in many age groups, in same-sex couples, between people of greatly different ages, in unmarried couples, in couples who are not sexually intimate, and it takes many different forms aside from physical violence.

Intimate partner violence is the term that has replaced domestic violence, and the definition of intimate partner violence is better suited for describing these varied and complex situations. The definition of intimate partner violence is broad. This is not intended as a criticism, but it is pointed out to underscore the fact that intimate partner violence can take many forms.

Intimate partner violence is any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the

This module will discuss intimate partner violence and two other forms of inter-personal violence, elder abuse and child abuse. All three are quite common in the United States, and all are underreported. The exact incidence of these social traumas is not known, but there is ample evidence that clearly indicates they are widespread as outlined below.

- Intimate partner violence, elder abuse, and child abuse can be emotional, physical, psychological, or sexual.

- The 2010 National Intimate Partner and Sexual Violence Survey estimated that more than 74 million people in the United States have experienced intimate partner violence, such as physical violence, sexual violence, or stalking, at some point in their lives; and, more than 12 million people had experienced intimate partner violence in the previous 12 months.[1]

- Intimate partner violence is the source of between 15% and 50% of all calls to police departments.[2]

- Several sources have estimated that the life-time prevalence of intimate partner violence experienced by women is 23.5% -
- 53.6% and by is men 7.9% - 16.4%.[3]

- It has been estimated that each year 8.2% to 16.5% of visits to emergency departments by women are related to intimate partner violence.[3] For men, the prevalence has been estimated to be 6.1% to 12.8%.[3] Intimate partner violence is also a significant problem for lesbian, bi-sexual, gay, and transgender (LGBT) individuals.

- Women are more likely to report intimate partner violence, but the reporting of it is still low. When women are victims of intimate partner violence approximately 84% will tell a family member or a friend, and 61% of men who are victims of intimate partner violence will tell a family member or a friend. However, only 21% of women and 6% of men will tell a doctor or a nurse.[4]

- In 2007 intimate partners committed 14% of all the homicides in the United States.[5] More than 40% of all female homicide victims in the United States are murdered by their husbands, boyfriends, or intimate partners.[6]

- Approximately 10% of elderly Americans are abused,[7] and some researchers feel that the incidence is much higher. State and local child protective services in the United States estimate there are 1 in 7 children in the United States that experience some form of maltreatment at a point in their lives.[8]

- Adolescent and young adult intimate partner violence has been recognized as a significant problem.[9,10]

Sections that follow in this study module will focus primarily on intimate partner violence as it affects women, however, the reader should keep in mind that the issues discussed and the topics covered here are relevant and applicable to all situations of inter-personal violence.

Intimate Partner Violence: Detection And Screening

Detecting intimate partner violence can be very difficult. As mentioned previously, many victims of intimate partner violence do not seek help or report their problems. Non-reporting of intimate partner violence is a complex issue and there are many reasons women (and men as well) may not seek help.[11,12] There are many barriers that prevent women and men from reporting intimate partner violence, and given the prevalence of the issue and the under-reporting by victims, nurses and other healthcare professionals must know how to screen for

intimate partner violence. This section addresses some recommended screening methods.

Why intimate partner violence is not reported

Women, in particular, may feel shame or embarrassment at being abused, or they may fear being judged by a healthcare provider. They may fear losing a loved one or losing a relationship that is perceived as stable. The abusive partner may threaten the woman with loss of her children or greatly restricted contact with the children. A woman who is a victim of intimate partner violence may, for various reasons, fear police involvement in her personal life. She may not be aware of the resources that are available, a language barrier may prevent her from using these resources, or prior experiences with authorities or social services may have been unproductive. Cultural or ethnic expectations and standards may prevent a woman from bringing her concerns to someone outside of her community.

Perhaps the biggest barrier that prevents women who are victims of intimate partner violence from seeking help is *fear* - fear that any attempt to make a change will incite further violence. This fear is well justified. Intimate partner violence against women is essentially an issue of control; and, if the abuser perceives any loss of control or there is a loss of control, such as, in the event that his partner leaves him or a restraining order is obtained, it is highly likely that the level of violence will intensify. If a woman attempts to break away from a violent partner, the level of violence almost always increases and most homicides that are associated with intimate partner violence occur when the woman attempts to leave or has already left.[13]

Screening for intimate partner violence

Women who have been emotionally, physically, or sexually abused by a partner may seek help, but as few as 1 in 20 of the victims will be identified by a nurse, physician, or other healthcare provider as a victim of intimate partner violence.[6] One reason for this underreporting is the lack of screening. Nurses and other healthcare professionals may not screen for intimate partner violence because of inadequate resources, lack of training[14], perceived lack of time, fear of making patients uncomfortable, or fear of retaliation from the abuser. Yet screening is important and should be done.

Several recent analyses of the benefits of screening for intimate partner violence have questioned its benefits,[15,16] nonetheless, there is literature that suggests the provision of training and support for healthcare professionals and an immediate available advocate designated for the emergency department can increase the incidence of detection of intimate partner violence.[17,18] The United States Preventive Service Task Force (USPSTF) in 2013 and the Institute of medicine recommend that women of childbearing age (14 to 46 years of age) be screened for intimate partner violence, and The American Congress of Obstetricians and Gynecologists recommends screening all women for intimate partner violence regardless of age.[19]

Selecting a screening tool to detect intimate partner violence

There have been extensive attempts to find the optimum screening tool for the detection of intimate partner violence. Many available screening tools exist; a list of over 30 intimate partner violence screening tools is available through the Centers for Disease Control

and Prevention (CDC).[20] The screening tools differ in length, complexity, the setting in which they would be most useful, and their sensitivity and specificity.

CDC identifies the recognition of intimate partner violence as key to stopping it: resources are available at http://www.cdc.gov/VIOLENCEPREVENTION/intimatepartnerviolence/.

A complete discussion of the details, drawbacks, and merits of all of these is beyond the scope of this module. The five that will be covered here have been determined to be at least 80% sensitive and 50% specific in identifying intimate partner violence in asymptomatic women[21], and, three have been determined by the USPSTF as most useful for screening in primary care settings.[19] The five screening tools are: 1) Hurt, Insult, Threaten, and Scream (HITS); 2) Ongoing Violence Assessment Tool (OVAT); 3) Slapped, Threatened and Throw (STaT); 4) Hurt, Afraid, Rape, Kick (HARK), and; 5) Women Abuse Screening Tool (WAST). These are further explained in the section below.

Hurt, insult, threaten, and scream (HITS)

The HITS screening tool consists of four questions that are answered in writing. These questions ask:

Over the last 12 months how often did your partner:

1. physically hurt you?
2. insult you or talk down to you?
3. threaten you with harm?
4. scream or curse at you?

The optional answers to the HITS questions are: *never, rarely, sometimes, fairly often, or frequently* and the answers are scored as 1 to 5, respectively. A score of > 10 are considered a positive indicator of the presence of intimate partner violence. Testing of the HITS screening tool has shown that it has very high sensitivity and specificity.[22]

A HITS screening tool that can be administered verbally has also been developed.[22] During an interview, the interviewer asks the interviewee:

1) Does your partner physically hurt you?
2) Does your partner insult you or talk down to you fairly often?
3) Does your partner threaten you with harm?
4) Does your partner scream or curse at you fairly often?

Any *yes* answer is considered to be a positive indication of intimate partner violence.

Ongoing violence assessment tool (OVAT)

The OVAT screening tool is a four question-screening tool that was developed in 2003,[23] which has been found to have high specificity, sensitivity, and negative and positive predictive value. This screening tool can be administered verbally or it can be filled out in writing.

During the OVAT screening assessment, if the interviewee answers *true* to questions 1, 2, or 4, or has a response of *occasionally* or *higher* to question 3, that would be considered to be a very strong indicator of the presence of ongoing intimate partner violence. The OVAT screening questions include:

1. Within the last month my partner has threatened me with a weapon:
   True or False
2. Within the last month my partner has beaten me so badly that I had to seek medical help:
   True or False
3. Circle the best response. Within the last month my partner has had no respect for my feelings:
   Never - Rarely - Occasionally - Frequently - Very frequently
4. Within the last month my partner has acted like he or she would like to kill me:
   True or False

Slapped, threatened and throw (STaT)

The STaT screening tool was developed in 2003. It is a three question screening tool that can identify any lifetime occurrence of intimate partner violence. The three questions were found to have a sensitivity of 96%, 89%, and 64%, respectively, and a sensitivity of 75%, 100%, and 100%, respectively.[24] The STaT tool can be administered verbally or it can be filled out in writing. Any *yes* answer to questions in the STaT tool is considered to be evidence of a lifetime occurrence of intimate partner violence. These questions include:

1. Have you ever been in a relationship where your partner has slapped or pushed you?
2. Have you ever been in a relationship where your partner has threatened you with violence?
3. Have you ever been in a relationship where you partner has thrown, broken, or punched things?

Hurt, afraid, rape, kick (HARK)

The HARK screening tool was developed in 2007 and it is another short, quick screening tool. The HARK assessment uses four questions that can be administered verbally or in writing. A *yes* answer to any of the HARK questions is scored as 1 point and a score of ≥ 2 accurately identifies women who have experienced intimate partner violence in the past year.[25] The HARK questions were found to have high specificity, sensitivity, and negative and positive predictive values.[25]

1. Humiliation:
   Within the last year, have you ever been humiliated or emotionally abused by your partner or ex-partner?
2. Afraid:
   Within the last year, have you ever been afraid of your partner or ex-partner?
3. Rape:
   Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
4. Kick:
   Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

Woman abuse screening tool (WAST)

The WAST screening tool has eight questions and is therefore longer and more complex than the four prior screening tools raised, but there is a two question short-form WAST that can be used. The WAST was developed in 1996 for use in family practice,[26] and it has been shown to be highly reliable. It can be administered verbally or in writing and three responses are possible. The WAST short-form is the first two questions of the WAST.

The WAST *short-form* is scored by assigning a value of 1 for the first response to either question and a value of 0 for the other two responses; for example, a score of 1, if the respondent said that she and her partner work out arguments with great difficulty. A score of ≥ 1 indicates intimate partner violence. Whereas, the WAST screening tool scoring is different than the WAST short-form: the response are scored as 3, 2, or 1 in descending order and a score of 13 or above has been found to indicate the presence of intimate partner violence.[27]

1. In general, how do you describe your relationship?
   □ A lot of tension □ Some tension □ No tension
2. Do you and your partner work out arguments with:
   □ Great difficulty □ Some difficulty □ No difficulty
3. Do arguments ever result in you feeling down or bad about yourself?
   □ Often □ Sometimes □ Never
4. Do arguments ever result in hitting, kicking, or pushing?
   □ Often □ Sometimes □ Never
5. Do you ever feel frightened by what your partner says or does?
   □ Often □ Sometimes □ Never
6. Has your partner ever abused you physically?
   □ Often □ Sometimes □ Never
7. Has you partner ever abused you emotionally?
   □ Often □ Sometimes □ Never
8. Has your partner ever abused you sexually?
   □ Often □ Sometimes □ Never

Which screening tool is the right one?

The screening tools for intimate partner violence mentioned above are short, simple, and intended to be used for identifying women who are

experiencing or have experienced intimate partner violence. They are also designed to detect the many different ways that intimate partner violence can be manifested, and not simply physical violence. There are longer and more complex screening tools available and they may be appropriate in certain circumstances.

The screening tools to identify intimate partner violence explained above are considered to be quite good and very reliable; however, there is no "perfect" screening tool. The examples of the screening tools that are provided here can be administered verbally or in writing, but there is some evidence that screening tools may be more effective and more acceptable if they are computer-assisted and self-administered.[28]

The situation of intimate partner violence is complicated and sensitive. The female victim of intimate partner violence may well be in a very precarious and labile emotional state. The screening tool and a follow-up interview should be conducted in privacy. When using the screening tool and interviewing the patient, tell the woman that what she says is confidential. Respect the woman's right to refuse to answer, but make sure that the victim understands that her problem is considered by the health team to be serious, that any intimate partner violence is illegal and wrong, and that she is not responsible for what has happened.

Each woman will have her own specific concerns, but research has shown the following to be influencing factors when female victims of intimate partner violence bring the problem to the attention of healthcare professionals: [29]

- They want to be treated with respect and concern.
- They want to be assured that they will be protected.
- They want the abuse to be documented.
- They would like to be given some control in the process of reporting.
- They would like an immediate response to the violence.
- They would like options.
- They are concerned that there will be good follow-up available.

Men and intimate partner violence

Intimate partner violence was traditionally considered to be violence by men against women, but men are quite often victims of physical and psychological violence by their partners, in both heterosexual and homosexual relationships. The phenomenon is almost certainly under-reported and definitely underpublicized, but it is not uncommon.

Men in traditional heterosexual relationships may not report intimate partner violence for familiar reasons, such as fear of the partner, but they may also feel ashamed at what they perceive as weakness or an inability to fulfill a traditional masculine role. Bias against gay men is still quite common, and gay men who are victims of intimate partner violence may be hesitant at discussing their lifestyle and sexual preference with healthcare professionals. In either case, the evidence is clear that intimate partner violence against men is *not* unusual. As mentioned in the introduction, the lifetime prevalence of intimate partner violence experienced by men is 7-.9% - 16.4%. [3]

Injuries And Behaviors Associated With Intimate Partner Violence And Health Consequences

There are variations in the pattern of intimate partner violence, but many cases follow what has been called the *cycle of violence*.[12] This is a pattern of abuse that has three separate phases: 1) tension building; 2) violence; and, 3) reconciliation.

During the tension building phase the abuser becomes increasingly angry despite the partner's attempt to placate or to be agreeable. At some point, violence is used, but after that the abuser will often be contrite, apologize, and attempt to re-establish a loving relationship. Female victims of intimate partner violence may not voluntarily report the violence or be willing to participate in a screening test.

Nurses must be aware of injuries and patterns of behavior that indicate the possibility of intimate partner violence.[12] Some cues to help the nurse or other members of the health team to identify victims during screening would be:

- Is the patient anxious, withdrawn, or depressed, especially when in the presence of her partner?
- Does the partner seem overprotective, does he try and dominate the interview and answer for the woman? Does he refuse to leave when asked?
- Does the patient appear malnourished?
- Is the patient depressed and/or expressing suicidal thoughts?
- Has the patient come to the healthcare facility many times before with vague, non-specific complaints?
- Does the patient have unexplained injuries to her breasts, rectum, or genitals? Sexual assault often accompanies physical and emotional violence.
- Are there unexplained injuries to the face, neck, or throat?

- Does the patient have bilateral, symmetrical injuries?
- Are there unexplained dental injuries?
- Are there obvious fingernail scratches, or wounds that could be cigarette burns or rope marks?
- Does the patient have subconjunctival hemorrhages?
- Does the patient have injuries at multiple sites?
- Are there slap marks with the impression of fingers?
- Are there any bite marks?
- Does the patient have defensive injuries to the wrists and/or forearms, or to the palms of the hand or the back of the head or neck? These injuries can occur when the victim is crouching on the ground to avoid further attacks.
- Was there a substantial delay between the time of injury and presentation to a healthcare facility?
- Is the patient's explanation for how the injury/injuries occurred inconsistent or illogical?
- Is the woman pregnant? Pregnancy is often a time when intimate partner violence increases in frequency and intensity.

This section has highlighted the variation of serious outcomes that can occur, which the interviewer can better identify through the use of an appropriate screening tool. There are many health consequences, physical and psychological, that are associated with intimate partner violence.[12,13,30-32] The tables below include some correlating medical and psychological conditions that have been identified with intimate partner violence.

General Medical Disorders

Asthma

Bladder/kidney infections

Circulatory conditions

Cardiovascular disease

Fibromyalgia

Irritable bowel syndrome

Chronic pain syndromes

Central nervous system disorders

Gastrointestinal disorders

Joint disease

Migraines/headaches

Reproductive Disorders

Pelvic inflammatory disease

Sexual dysfunction

Sexually transmitted infections, including HIV/AIDS

Delayed prenatal care

Preterm delivery

Pregnancy difficulties like low birth weight babies and perinatal deaths

Unintended pregnancy

Psychological Disorder

Anxiety
Depression
Symptoms of post-traumatic stress disorder (PTSD)
Antisocial behavior
Suicidal behavior in females
Low self-esteem
Inability to trust others, especially in intimate relationships
Fear of intimacy
Emotional detachment
Sleep disturbances
Flashbacks/Replaying assault in the mind
High-risk sexual behavior (unprotected sex, decreased condom use, multiple sex partners, trading sex for money)
Using harmful substances (alcohol, cigarettes, illicit drugs)
Unhealthy diet-related behaviors (fasting, using/abusing diet pills, overeating, inducing vomiting)
Overuse of health services

Elder Abuse Screening

Elder abuse is defined as the "intentional or neglectful acts by a caregiver or trusted individual that lead to, or may lead to harm of a vulnerable elder."[33] Elder abuse in the United States is common. Evidence indicates that 1 in 10 older American adults are abused in some form and that the true incidence is much higher.[34] Unfortunately, many cases of elder abuse go unreported: several studies have shown that only 1 out of 14 or 1 out of 24 cases of elder abuse are brought to the attention of authorities.[35] A 2012 study of a low-income Latino

community showed that 40% of older adults had been abused in the past year but only 2% of these cases were reported.[36]

Elder abuse, like intimate partner violence, can take many forms. The National Center on Elder Abuse has defined seven categories of elder abuse.[37]

1. Physical abuse:

   The use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.

2. Emotional or psychological abuse:

   Inflicting anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment”; and enforced social isolation are examples of emotional/psychological abuse.

3. Financial or material exploitation:

   The illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission;

forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document, such as a contract or will; neglecting duties to an elder.

4. Neglect:

   Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

5. Sexual abuse:

   Non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

6. Self-neglect:

   Behavior of an elderly person that threatens his/her own health or safety. An older person may refuse or fail to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medications, and safety precautions.

7. Abandonment:

   The desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Risk factors for elder abuse include characteristics of the elder adult, specific living and social conditions, and characteristics of the abuser.[38] The victim is often in poor health, lacks mobility, is in frail condition, and/or has a disability or dementia. Elder women are abused more often than elder men. Social isolation increases the risk of abuse as does poverty or financial resources that can be exploited. People who abuse the elderly are usually family members. They often have alcohol or substance abuse problems or mental health problems.[39]

The rate of detection by healthcare professionals of elder abuse is typically very low. [40] Typical injuries/situations that are suggestive of elder abuse include: 1) unexplained injuries; 2) repeated injuries to the same area; 3) injuries on or around the head, face, and neck; 4) changes in mental or physical functioning that suggest over-medication or under-medication; 5) sexually transmitted diseases in a person who is not sexually active; 6) signs/symptoms of dehydration or malnourishment; 7) unexplained financial hardship; 8) fear and anxiety, especially when a caregiver or relative is proximate; 9) delay in seeking treatment for illness or injury; 10) characteristic burns, decubitus ulcers, or odd/unusual injuries, and; 11) an inconsistent or illogical explanation for an injury. These are clear warning signs that elder abuse may be occurring.

In the absence of obvious indications for elder abuse, screening tools can be used to detect elder abuse. The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations), National Center on Elder Abuse, National Academy of Sciences, and the American Academy of Neurology all recommend routine screening, and the American Medical Association recommends

routine inquiry about elder abuse.[41] There is no universal agreement on which screening tool should be used and there are many available.[42,43] Some of the commonly used tools are described below.

Brief abuse screen for the elderly (BASE)

This screening tool for elder abuse is comprised of five questions:

1. Is the client an older person who has a caregiver?
2. Is the client a caregiver of an older person?
3. Do you suspect abuse?
4. What kind of abuse do you suspect?
5. If abuse is suspected, how soon do you estimate that intervention is needed?

This is a paper-screening tool, filled out by a healthcare professional. It is not an assessment tool, it is simply a *first-line* screening tool that alerts to the possibility of elder abuse. An assessment tool, an interview, and a medical work-up if indicated should follow it.

Caregiver abuse screen (CASE)

This screening tool is comprised of eight questions that are asked of the caregiver:

1. Do you sometimes have trouble making the person you are caring for control his/her temper/aggression?
2. Do you often feel you are being forced to act out of character or do things you feel bad about?
3. Do you find it difficult to manage the temper of the person you are caring for?
4. Do you sometimes feel you are forced to be rough with the person you are caring for?

5. Do you sometimes feel you feel you can't do what is really necessary or should be done for the person you are caring for?
6. Do you often feel you have to reject or ignore the person you are caring for?
7. Do you often feel so tired or exhausted that you cannot meet the needs of the person you are caring for?
8. Do you often feel you have to yell at the person you are caring for?

As with the BASE screening tool, the CASE is a paper and pencil screening tool that is intended to alert healthcare professionals of the possibility of elder abuse. An assessment tool, and interview, and a medical work-up if indicated should follow it.

Indicators of abuse screen (IOA)

The IOA screening tool is longer and more in-depth than the BASE or CASE screening tools. It evaluates the caregiver and the person being cared for, and evaluates past history of abuse, history of important relationships, financial status of the caregiver and the person being cared for, *etc*. It is a 27-item assessment and evaluation that requires an interview and assessment with the elderly patient and caregiver/family member.

The caregiver is assessed on a scale of 0 = non-existent to 4 = severe of issues such as presence of substance abuse, care-giving reluctance, lacks understanding of medical problems, and presence of emotional/psychological difficulties. The care receiver is assessed on the same scale for the presence of issues such as cognitive impairment, physical impairment, past abuse, and social isolation.

Elder abuse suspicion index (EASI)

The EASI is a six question, *yes or no* answer-screening tool. One or more positive responses to questions two through six suggest the possibility of elder abuse. The patient answers the first five questions and the interviewer answers the sixth. The patient is asked, ”Over the last 12 months”:

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
6. Elder abuse might be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the past 12 months?

These screening tools and assessments are used along with a physical exam, a medical and surgical history, and a longer interview, preferably with the patient away from caregivers/family members who may be the abusers. As with all of the forms of inter-personal violence discussed in this module, barriers to revealing elder abuse are

common and many older adults do not willingly reveal that they are being abused.[39]

Screening For Child Abuse

The Child Abuse Prevention and Treatment Act defines child abuse as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation" or "an act or failure to act which presents an imminent risk of serious harm."[44] Each state has its own definition of child abuse based on this standard.

Child abuse is an enormous social problem in the United States. In 2011 the rate of child maltreatment was estimated to be 9.1 cases for every 1000 children,[45] and many children are abused multiple times. The fatality rate in 2011 that resulted from abuse and maltreatment was 2.1 deaths per 100,000 children,[45] and child abuse is the third leading cause of death in children ages one to four.[46] The abuse and maltreatment of children can be physical, psychological, and sexual abuse, and neglect: neglect is the most common form of child abuse.[45]

Child abuse often is not detected until the child suffers a severe injury or death.[46] Unfortunately, there is no evidence that any screening tool is highly effective for detecting and preventing child abuse or maltreatment.[47] Healthcare professionals must depend on a combination of awareness of the problem and knowledge of patterns of behavior and injury that are very suggestive for the presence of child abuse. Some of these include: [45,46]

1. Fractures:

   Fractures are a very common injury in children but between 12% and 20% of all fractures in children are caused by physical abuse.[48] Certain types of fractures should be considered to be highly specific as signs of abuse: classic metaphyseal lesion (a.k.a., CML, a fracture that crosses the metaphysis, commonly called the growth plate); rib fractures, especially postero-medial; scapular fractures; spinous process fractures, and; sternal fractures. [45,48]

2. Unexplained or poorly explained injuries or injuries incompatible with the explanation.

3. Odd or unusual injuries, especially to the head, face, or neck. The TEN-4 rule can be used to evaluate these injuries. The TEN-4 rule is that any bruising or injury to the ***t****orso*, ***e****ars*, or ***n****eck* in a child four years of age or younger *or* any bruising in a child four months of age or less should be considered as an indicator of child abuse.

4. A persistent pattern of injuries, i.e., the same type of injury or an injury to the same area of the body.

5. A delay in seeking treatment after an injury to a child or a delay in seeking treatment for a child's illness.

6. Signs and symptoms of abusive head trauma (formerly known as shaken baby syndrome). These include: altered mental status, apnea, coma, increased head circumference, irritability,

fussiness, and vomiting. Intracranial trauma (particularly subdural hemorrhage), CMLs, rib fractures, retinal hemorrhages, or secondary cerebral edema are also signs of abusive head trauma.

7. Failure to thrive, evidence of malnutrition, low body weight.

8. Burns that do not have the appearance of being caused by an accident.

9. A child that is agitated, fearful, or withdrawn when the caregiver or parent is present.

10. A child that appears apathetic or depressed.

Causes Of Intimate Partner Violence, Elder Abuse, And Child Abuse

There are many possible causes of intimate partner violence. Although abusers are not a homogeneous group and the pattern of abuse differs from person to person, research on why people abuse their partners has found several persistent themes.

1. Substance abuse:
   Abuse of both alcohol and illicit substances has been strongly and consistently linked to intimate partner violence. [49,50]

2. Child abuse:
   Children who have been abused or have witnessed abuse are more likely to become abusers and use intimate partner violence.[51]

3. Psychopathologies:
   Bipolar disorder, post-traumatic stress disorder (PTSD), and (possibly) attention deficit hyperactivity disorder have been identified as risk factors for intimate partner violence.[52] The prevalence of depression, generalized anxiety disorder, panic disorder, and social phobia was noted to be high in a group of men who had been arrested for domestic violence.[53]

4. Cognitive and social skills deficiencies:
   Researchers have noted that there is a significant difference in the cognitive processes and social skills between violent and non-violent men.[54-57] Perpetrators are likely to have high levels of anger, low levels of cognitive flexibility, cognitive empathy, and emotional recognition, and a high level of hostile sexism. They often have low self-esteem and antisocial tendencies, [58] and the psychopathologies of bipolar disorder and PTSD that have been identified as risk factors for intimate partner violence are associated with poor impulse control and impaired executive functioning.

5. Genetics:
   There may be genetic risk factors for intimate partner violence,[59] but the research in this area is inconclusive.

The causes of elder abuse and child abuse are similar to those of intimate partner violence. In addition to substance abuse, psychopathologies, and the other factors outlined above, caregiver burnout, behavioral problems or disabilities in an elder adult, a history of having been abused, dementia in an elderly adult, external stress, and social isolation can all cause people to abuse an elderly adult.[60] Many of these same factors will cause adults to abuse a child. In addition, several studies have shown that adults who are likely to abuse a child can be identified by certain risk factors: the presence of intimate partner violence; intoxication and/or substance abuse; suicide attempts or auto-mutilation, and; perceived and actual difficulties in child-rearing.[61-63]

Intimate Partner Violence: Help And Solutions

There is not a single approach that can be used to help all victims of intimate partner violence. Some people have been physically injured, some have not, the victim may be ready to discuss the situation and take action, but she/he may be undecided and unsure about seeking help.

The first step is to determine if there are any immediate physical and psychiatric concerns. If yes, any injuries, medical, and/or psychiatric issues should evaluated and treated. The next step would be reporting. In many states and municipalities it is mandatory to report to the police any harm that is assumed to be, or proven to be from intimate partner violence: someone who is knowledgeable about the local laws/requirements should be consulted. The Joint Commission does require that all healthcare facilities address the issue of intimate

partner by having policies in place for the identification, evaluation, management, and referral of victims of intimate partner violence.

If the victim has decided that he/she is not going to separate from the abuser the risk for immediate and serious harm should be assessed. The following have been identified as risk factors for significant danger (possible homicide) to a female victim of domestic violence:[64]

- There are weapons in the house.
- The violence has been increasing in frequency and intensity.
- The abuser uses drugs and/or alcohol to excess.
- Weapons have been used to abuse and injure.
- Abuse has resulted burns, broken bones, etc.
- Being forced into sex or into unwanted sex acts.
- Threats to kill.
- Killing of pets.
- Threats of suicide.
- The abuser is violent towards children.
- The abuser is violent outside the home.
- Abuse during pregnancy.

If these risk factors exist then social services should be contacted, the police should be notified, and if the victim has decided that she/he is going to leave the abuser arrangements will need to be made for a place to stay and if applicable, child care. If, despite ongoing abuse someone decides that she/he does not want to leave her/his partner, a safety plan should be made. The victim should be provided with emergency numbers and made aware of available legal and social resources, such as police protection and shelters. The victim should be advised to have money, clothing, and important documents pre-

collected and have a clear idea as to who to call and where to go if the violence reoccurs. It is also helpful to have the telephone numbers and websites of national organizations that can help victims of intimate partner violence.

- The National Coalition Against Domestic Violence. www.ncadv.org 303-839-1852. The website contains a state-by-state listing of all the national chapters along with their 1-800 numbers.
- National Violence Domestic Hotline. 1-800-799-7233
- Family Violence Prevention Fund. www.fvpf.org 415-252-8900

Breaking off a relationship with an abusive partner is often the time during which violence is the most intense and homicide is likely. If the victim has decided to leave the abuser, encourage her/him to take the following steps:

- Contact one of the hotlines listed above.
- Change phone number.
- Screen calls.
- Avoid being alone.
- Change locks.
- Only meet the partner in a public place.
- Vary the daily routine.
- Get legal help.
- Collect all of the important documents, e.g., social security cards, birth certificates, marriage license, leases or deeds, checkbook, and any documentation (police reports, photographs, ER records) of the abuse.

Legal help may involve obtaining a personal protection order, a court-ordered injunction that prohibits the abuser from contacting the victim. These are especially useful if the victim has decided to take steps to end the abuse, but does not want to, or can't file criminal charges. A personal protection order is typically issued for an effective period of 1 to 2 weeks. After that, the court will review the situation and determine if the protection order should be continued, for how long or if it should be stopped. If the abuser violates the condition of the personal protection order, she/he can be incarcerated. It should be remembered that the requirements for filing a personal protection order could be a significant obstacle for some victims. The victim may need money she/he does not have, the state may not recognize same sex relationships, and some states require that criminal charges be filed along with the petition for the personal protection order.

There is no national system for reporting elder abuse, but reporting elder abuse is mandatory for healthcare professionals in almost every state and eight states have laws that require members of the general public to report elder abuse. If elder abuse is suspected or proven, the local Adult Protective Services branch should be contacted. The National Center on Elder Abuse can be called at 1-800-677-1116, Monday-Friday, 09:00-20:00, EST, and operators can provide the telephone number for the local Adult Protective Services branch. If the elder abuse is of an emergent nature or during the night and weekends, 911 should be called.

Reporting child abuse is mandatory for healthcare professionals, and many states require mandatory continuing education for certain healthcare professionals on the topic of child abuse. Many states also

have laws requiring members of the general public to report child abuse. Each state has its own system for reporting child abuse; usually the local Child Protective Services agency, a local hotline, or local law enforcement. The National Child Abuse Hotline, 1-800-4-A-CHILD is available 24 hour, seven days a week, and can direct callers to local resources for reporting child abuse.

Intervention Programs For Batterers

Court ordered batterer intervention programs are the most commonly used method of treating men who use intimate partner violence. It has been estimated that, in any given year, close to 500,000 men in the United States are enrolled in a batterer intervention program.[65] These programs are typically 12-52 weeks long, and they try to prevent intimate partner violence by having perpetrators examine and understand their attitudes and behavior, particularly as they apply to issues of control, gender, and power in the relationship. Learning how to control anger is stressed and communication skills are taught in batterer intervention programs. The perpetrators are also expected to hold themselves accountable for the violence. There is little evidence to support the structure of these intervention programs, and their efficacy has been questioned but in many instances they are mandatory.[65,66]

Summary

Domestic violence, violence that happens in the context of relationships, is a complex phenomenon. Children, the elderly, men, and women are all victims of domestic violence. The pattern of violence suffered by each of these groups is different, but there are

similarities, as well. The true incidence of these types of violence is unreported; this is due to the fact that the violence is often ongoing, it is not an isolated event, the victims often do not or cannot report the problem, and, healthcare professionals often are unable to identify victims. Because intimate partner violence, elder abuse, and child abuse are so widespread and because the victims often cannot or do not advocate for themselves, nurses have a responsibility to:

1. be aware of these problems
2. be familiar with risk factors and patterns of injury associated with intimate partner violence, elder abuse, and child abuse
3. understand how and to whom intimate partner violence, elder abuse, and child abuse should be reported

An in-depth understanding of these forms of interpersonal violence is not necessary, nor do nurses have a responsibility to adopt the role of social worker or therapist. Nurses are often the first healthcare professionals to encounter victims of intimate partner violence, elder abuse, and child abuse, and within the scope of their practice nurses should be expected to identify these victims and know how to help.

Please take time to help NurseCe4Less.com course planners evaluate the nursing knowledge needs met by completing the self-assessment of Knowledge Questions after reading the article, and providing feedback in the online course evaluation.

Completing the study questions is optional and is NOT a course requirement.

1. Intimate partner violence can be

a. physical, psychological, or sexual

b. emotional or medical

c. physical only

d. psychological or financial

2. True or false: Most victims of intimate partner violence report the problem.

a. True

b. False

3. In intimate partner violence the risk of homicide is greatest

a. at the beginning of the relationship

b. if the perpetrator abuses alcohol

c. if there is a significant age difference between partners

d. if the woman tries to, or does leave

4. A significant barrier preventing intimate partner violence victims from seeking help is

a. age

b. fear

c. gender

d. health

5. Elder abuse can be in the form of

a. psychological

b. financial

c. sexual

d. all the above

6. Risk factors for elder abuse include

a. dementia and social isolation.

b. male gender and ethnic background.

c. family size and age > 80.

d. female gender and rural environment.

7. Which of the following are highly indicative of child abuse?

a. Chronic upper respiratory infections, fractures.

b. Delay in seeking treatment for a child's illness, any burn.

c. Poor appetite, fear of healthcare personnel.

d. CML and rib fractures, unexplained injuries.

8. Child abuse should be suspected if

a. a child < 10 years has bruising of the ears or torso.

b. a child ≤ 4 years has bruising/injury to the torso, ears, or neck.

c. a child ≤ 4 years has a lower limb fracture.

d. a child <5 years has a persistent nosebleed.

9. Many perpetrators of intimate partner violence, elder abuse, or child abuse

a. have no close relationship to the victim.

b. are women under the age of 40.

c. have a substance abuse problem or a psychiatric disorder.

d. will readily admit that they are violent.

10. Reporting child abuse is

a. mandatory for many healthcare professionals.

b. only done if the abuse has been witnessed.

c. optional for many healthcare professionals.

d. done only if the child has suffered physical injuries.

Correct Answers:

1. A
2. B
3. D
4. B
5. D
6. A
7. D
8. B
9. C
10. A

References Section

The reference section of in-text citations include published works intended as helpful material for further reading. Unpublished works and personal communications are not included in this section, although may appear within the study text.

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