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Addressing Intimate Partner Violence

Guidelines for Health Professionals in Maternity and Child Health Care

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Foreword

This guidebook is part of the project "Good practice in screening of victims of violence in intimate partnerships in maternity and child health services". The project was funded by the EU Commission's Daphne Programme II and co-financed by the Ministry of Social Affairs and Health in Finland. The project was carried out in 2005/2006.

The aim of the project was to evaluate if the intimate partner violence screening tool developed in Finland were applicable in other European countries. During the project the screening tool was still further developed so as to become a model for daily routine in identifying intimate partner violence and violence against children in the family at an early stage. The project also aimed at acknowledging different cultural backgrounds and at benefiting from the results of previous research studies and developments in other European countries.

The co-ordinating organisation was the Palmenia Centre for Continuing Education (University of Helsinki) in Vantaa. The other partners from Finland were the Health Centre in Vihti, Helsinki University Central Hospital HUCH / Women's Hospital and the National Women's Line in Finland. Transnational partners were the Tartu Health Centre and NGO Tartu Women's Shelter (Estonia), Vilnius Maternity Hospital, Women's Issues Information Centre and Vilnius Home for Mothers and Children (Lithuania), the Department of Medicine (University of Crete) and the Centre for Research on Women's Issues (KETHI) in Heraklion and Thessaloniki (Greece) and Social Change - Institute for Innovation in Gender Studies and Violence Prevention (Austria) (see also Annex 1).

The background of the project was a pilot project carried out in Finland from 2000 to 2003. The aim of that project was to establish an adequate method for identifying, addressing and discussing intimate partner violence in maternity and child health clinics and to develop a screening tool for daily routine. Several maternity and child health clinics in Finland participated in the project. As part of the project two studies were carried out which showed that violence in intimate partnerships is common in Finland. Women experienced also violence during pregnancy and childbearing years (see Annex 2).

This guidebook introduces a screening tool developed in Finland. It also provides guidance for health professionals working in maternity care and child health clinics on how to identify intimate partner violence and to support victims of such violence. In Finland the screening tool is used in maternity clinics as part of the regular checkups during pregnancy as well as in checkups of infants in child health clinics. The use of the screening tool is recommended by the Ministry of Social Affairs and Health.

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1 Introduction

Aim of the guidebook

This guidebook would like to highlight the important role that health professionals in maternity and child health care play in supporting women victims of intimate partner violence. It should provide the health professionals with a practical tool to support and guide them in their efforts to recognise violence at an early stage and prevent further violence. This guidebook is intended to make it easier to integrate asking about violence into daily routine. Asking about intimate partner violence is also a way of protecting children as well as primary prevention of violence occurring in the family.

Routine enquiries in maternity and child care should be introduced so that women and their children receive adequate support in case of intimate partner violence. Routine enquiries should be based on standardised screening questionnaires and screening should not be done without having received training on intimate partner violence, its consequences for women and their children and on how to use the screening questionnaire.

Definitions

Intimate partner violence is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person, usually a man, over another, usually a woman, within the context of an intimate relationship. It can be manifested in a variety of ways, including but not restricted to, physical, sexual, emotional, and financial abuse, and the imposition of social isolation and is most commonly a combination of them all (Greater London Authority 2001).

Although this guidebook primarily deals with intimate partner violence (IPV) all other forms of violence against women are as serious as IPV.

Intimate partner violence as a global health issue

Violence is a serious threat to women's, children's and unborn babies' health; it impairs their physical and emotional well-being in the short- and long-term. Violence ranks as one of the leading causes of injury and death for women. Besides self-inflicted and collective violence, which of course also affect men, it is predominately interpersonal violence which can certainly not be discussed without the gender perspective; interpersonal violence has a clear gender-bias.

"Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex partnerships, the overwhelming burden of partner violence is borne by women at the hands of men." (WHO 2002: 89).

Intimate partner violence is very likely the most widespread form of violence against women, especially in highly developed regions like Europe. The WHO refers to 48 population-based surveys from around the world which show that between 10% and 69% of women have been physically assaulted by an intimate male partner at some point in their lives (WHO 2002: 89).

Violence against women puts a heavy burden on the health system, it reduces women's working capacities, the quality of their lives and their lifespan. In highly developed countries like the US partner abuse is the most common reason for injuries in women.

Violence does not stop during pregnancy – on the contrary. The time of pregnancy and after delivery can pose an even greater threat to women to be afflicted by intimate partner violence.

In the 1990s intimate partner violence was identified as a major risk to women's health, not least thanks to a series of studies. In countries like the US, Canada, the UK and Australia research was carried out to specifically explore the link between intimate partner violence and pregnancy / postpartum (Johnson et al. 2003; Huth-Bocks et al. 2002). The earliest studies conducted in the US, Canada and Australia took only physical violence into account but found that between 0.9% and 20.1% of women had experienced violence during pregnancy (Gazmararian et a. 1996). In the United States it is estimated that one out of six adult women and one in five pregnant teenagers are a victim of physical violence. Research also shows that there is a higher risk of becoming a victim of violence during pregnancy than being afflicted by diseases like diabetes and toxemia of pregnancy which are routinely screened in maternity care.

It has become evident that pregnancy a) poses a special risk to women, especially if they have been experiencing violence before, and b) offers an excellent opportunity for health professionals to identify victims of violence and help and support them.

In research projects models for identifying such violence and adequately supporting women have already been developed. Experience has shown that more cases of domestic violence can be elicited when health professionals have received training and repeatedly ask about violence. Many research findings also point to the importance of using screening instruments and questionnaires since they significantly increase the rate of detection. This guidebook introduces instruments and questionnaires used in health care services for the identification of violence (see Annex 3, page 48).

However, the failure of health professionals to identify intimate partner violence and offer appropriate support is a significant problem (Bacchus et al. 2004a). Although, for example in the UK, various bodies have developed guidelines for assessing domestic violence in health settings and have emphasised the need to offer advice it remains doubtful if these recommendations have been implemented so far (Bacchus et al. 2004b).

A brief summary of research on violence during and after pregnancy can be found in Annex 4 (see page 49). Annex 5 introduces further recommendable literature on the subject (see page 58).

2 The role and responsibilities of health professionals

The health professionals, especially in maternity and child care, are in a good position to help and support women who experience intimate partner violence. Routine health checkups during pregnancy and after delivery, often required for receiving certain social benefits, offer an excellent opportunity to recognise victims of abuse. Moreover, confidentiality required from health professionals is a very good basis for women to talk about their experience. However, it is important that health professionals initiate a conversation about violence and abuse since women usually find it very hard to talk about their experience due to shame, embarrassment, fear of the consequences and feeling that the health professional would not be able to help (Bacchus et al. 2002).

Routine enquiries for intimate partner violence should be introduced. All women should be offered confidential time in at least one appointment. If concern arises in any situation it should always be possible to address it.

However, health professionals are just one group in a system of support that is necessary to fully help victims of violence. The special role of the health professional is in identifying victims of violence and in initiating a process of ending this violence. It is therefore important that they co-operate with other help providers and authorities. It is also helpful if clinics and doctor's practices have information posters, leaflets and information cards available.

The responsibilities of health professionals are:

- to recognise violence
- to bring up the issue of violence
- to interview, support and advise the victim
- to assess the dangerousness of the situation
- to carry out a careful medical examination and statement
- to document the impact of violence (injuries, psychological impact, etc.)
- to talk about the children
- to report the violence in accordance with child protection laws
- to refer victims to other help providers
- to co-ordinate co-operation with other professionals

Key issues in maternity and child care

- Young pregnant women and mothers of infants are at special risk of becoming victims of intimate partner violence: Identify the victims, address the violence and talk about its impacts.
- Talk to the women about their experiences in their relationships. Pay special attention to men's controlling behaviour (subordination, isolation and frightening behaviour)
- Asking about violence should be part of daily routine. Every woman should be asked by making use of a standardised screening instrument.

Helping victims of violence is first of all part of the professional ethical obligations.

3 Recognising violence

Recognising violence at an early stage is not an easy task. Yet, research was able to name factors that can help health professionals to identify victims of violence. Lists of indicators about violent behaviour have been elaborated but in order to recognise violence additional information about the woman's condition and life situation is needed.

Women are very hesitant to start talking about violence. But if abused women ask for help from public institutions, it is very likely that they will turn to health professionals. Usually women do not ask for help until the abuse has continued for a long time. That is why it is important to develop operational models in maternity and child health care which improve early recognising of violence and bringing up the issue.

Signs that indicate violence:

- A woman arrives at the maternity care at a later stage of pregnancy than usual.
- The pregnant woman is quite young or a teenager.
- The pregnancy is not planned or undesired.
- She seems busy and anxious.
- She cancels/forgets appointments.
- She looks untidy.
- Her life / family life is characterised by social isolation/she is only in contact with very few relatives and friends.
- She complains of being irritated, impatient and tired (also when taking care of her child/children).
- She has had miscarriages/abortions.
- She smokes or has increased smoking.
- She uses alcohol or has increased the use of it.
- She uses drugs.
- She uses sleeping or anti-depression medication or tranquillizers.
- She has complications during pregnancy such as renal or urinary infections, gynaecological infections, early labour contractions or premature births.
- She has physical injuries (usually rashes, scratches, wounds, bruises, contusions, burns or fractures).
- She has a history of continuous injuries and accidents (falling, slipping, stumbling, etc.).
- The injuries are located in areas covered by clothes: upper body, arms, head (especially scalp), legs, belly.
- She shows psychosomatic symptoms like different pains, insomnia, nightmares, eating disorders, unusual changes in weight.
- She is afraid of the delivery.
- She is under panic during delivery.
- Her behaviour changes when her husband/partner is present.
- Her husband/partner behaves over-attentive or he plays down the situation, is irritated by or behaves impatiently towards his wife/partner and/or the children.
- Her husband/partner wants to be fully involved and does not want to leave her alone at all.
- She or/and her husband refuses further treatment/services.

Indicators of physical violence

- Injuries: bruises, wounds, bone fractures, concussions, tooth injuries, scalp injuries, internal injuries, miscarriages, eardrum ruptures, burns.
- Injuries do not match the explanation given for them.
- Injuries she cannot/ does not want to explain how she got them.
- A history of unexplained injuries.
- A history of recurrent injuries.
- Injuries in well protected parts of the body.
- Burns on unusual locations or of unusual type.
- Delay between injuries and seeking treatment.

Indicators of sexual violence

- Injuries to the genitals, anus, inner thighs and breasts.
- Genital, urinary or rectal irritation.
- Frequent infections in the genitals and/or urinary tracts.
- Pain in or itching of genital and/or rectal area.
- Abdominal or pelvic pain.
- Sexually transmitted infections/diseases.
- Vaginal or rectal bleeding.
- Painful defecation or painful urination.
- Having difficulties in walking and/or sitting.
- Having difficulty with or avoiding pelvic exams.
- Vaginism (spasms of the muscles around the vagina) in a gynaecologic examination.
- Overt sexual behaviour/language (sexual "acting out").
- "Love" bites.
- Unwanted pregnancy/abortion.

Indicators of financial violence

Elderly women are often victims of financial violence although young(er) women can be affected, too.

- poverty
- homelessness
- debts
- unable to provide food and necessities for the family
- unpaid bills/inability to pay bills
- inadequate food/clothing
- unexplained discrepancy between income and living conditions

However, it is important to be aware of that no single factor can accurately predict if a woman is a victim of violence. Some women may show a range of symptoms or none at all.

4 Psychological trauma caused by violence

Psychological trauma is the consequence of insuperable, uncontrollable experiences which can happen to anyone and which often lead to experiencing helplessness, vulnerability and lack of control over one's own life. (Everstine & Everstine 1993).

Acute trauma reactions

Acute trauma reactions are shock reactions which can last from a few hours to a few days. They may also be delayed for one to three days and last from some days to four to six weeks. Acute trauma reactions are normal reactions to a traumatic event. The following behaviour/symptoms can occur simultaneously.

Observable behaviour/symptoms:

- Agitation (motor anxiety; pacing up and down, inability to sit still, wringing hands, weeping, hostile attitude and behaviour)
- Conversion (loss of voice, vomiting, pain and ache, a lump in the throat, dizziness)
- Calmness, apathy and impassivity or stupor (immobility, seems not to notice her surrounding)
- Irrational behaviour (e.g. giggling, constant laughing)
- Rational behaviour by totally denying the psychological impact of the violence (e.g. telling calmly about being raped)

Emotional/cognitive symptoms:

- anxiety, panic, confusion
- numbness
- disbelief ("This cannot be true")
- memory gaps
- impaired ability to think/function
- distorted perception of time
- loss of feelings (frozen fright)
- depression, feelings of worthlessness
- guilt, shame
- dissociation
- depersonalisation, disorientation, out-of-body-experiences, hallucinatory experiences
- amnesia

Long Term Symptoms / PTSD (Post-Traumatic Stress Disorder)

Long-term symptoms are signs and changes in the individual behaviour, emotions, relationships, social life, personality characteristics, life situation and/or health condition. Acute trauma reactions and long-term symptoms can be confounded.

PTSD (Post-Traumatic Stress Disorder) is a medical diagnosis for long-term symptoms caused by repeated events that involve one's threatened death, serious bodily injury or the threat to one's physical integrity. Repeated attacks, physical proximity to the stressor (= perpetrator) and perceiving events as uncontrollable and unpredictable increase the risk of developing PTSD. Other traumatic situations can also produce PTSD (e.g. being held hostage, tortured, raped, kidnapped, robbed). PTSD can be especially severe or long-lasting when the stressor is a human being (instead of a natural catastrophe). Extreme stress affects victims in many ways: somatic, emotional, cognitive, behavioural and characterological. It can lead to a variety of psychiatric disorders, such as dissoziative disorders, eating disorders, substance abuse and self-destructive behaviour (Dutton 1995; van der Kolk et al. 1996).

However, developing PTSD is a complex process:

Trauma reactions do not inevitably lead to mental disorder (disease model) but many abused and battered women suffer severe symptoms known as PTSD.

PTSD needs to be seen as the result of an entrapment process due to coercive control by the perpetrator which leads to the victim's experience/conclusion that escape is impossible.

PTSD symptoms need to be seen as normal human responses to an insuperable experience on mind, body and society (interpersonal and institutional trauma).

Different coping strategies significantly reduce the consequences of trauma.

Emotional/cognitive symptoms

- fearful behaviour/ongoing watchfulness/gasp reactions
- lack of interest in things/depression
- excessive dependence or isolation
- hostility, irritability or outbursts of anger
- rapid changes of mood/ambivalence
- feeling of loneliness/being different/stigma
- feeling permanently damaged (foreshortened future)
- anxiety/feeling trapped
- loss of feelings/"frozen self"
- sleeping disturbances: trouble falling asleep or staying asleep, insomnia, nightmares
- increased use/dependence of/on drugs/alcohol
- suicidal tendencies (thoughts/attempts/committed suicides)

Behavioural symptoms

- loss of relationships with relatives, friends
- poor or no participation in social life/hobbies/always having to hurry home
- numb/submissive behaviour
- going back on decisions, forgetting appointments
- withdrawal and isolation
- avoiding situations/places/conversations associated with the trauma
- difficulties concentrating on things (e.g. books, TV)
- poor parenting responses, child abuse

Somatic symptoms/illnesses

- unexplained physical symptoms: pains, aches (e.g. headache)
- hypertension
- stomach pain/gastric ulcer
- colon irritable
- menstrual disorders
- pain in the chest/cardiac region/arrhythmia/infarct
- difficulty in breathing/asthmatic symptoms/asthma
- eating disorders:
- loss of appetite/ weight
- excessive eating/extreme obesity

Consequences of trauma – why doesn't she leave?

The impact of trauma makes it very difficult for women to leave a violent partner. Gradually progressing assaults, mistreatment, intimidation and threats - which cause a traumatic bond - play an essential role. The central elements in the traumatic bond are the use of power and control and the cycle of violence.

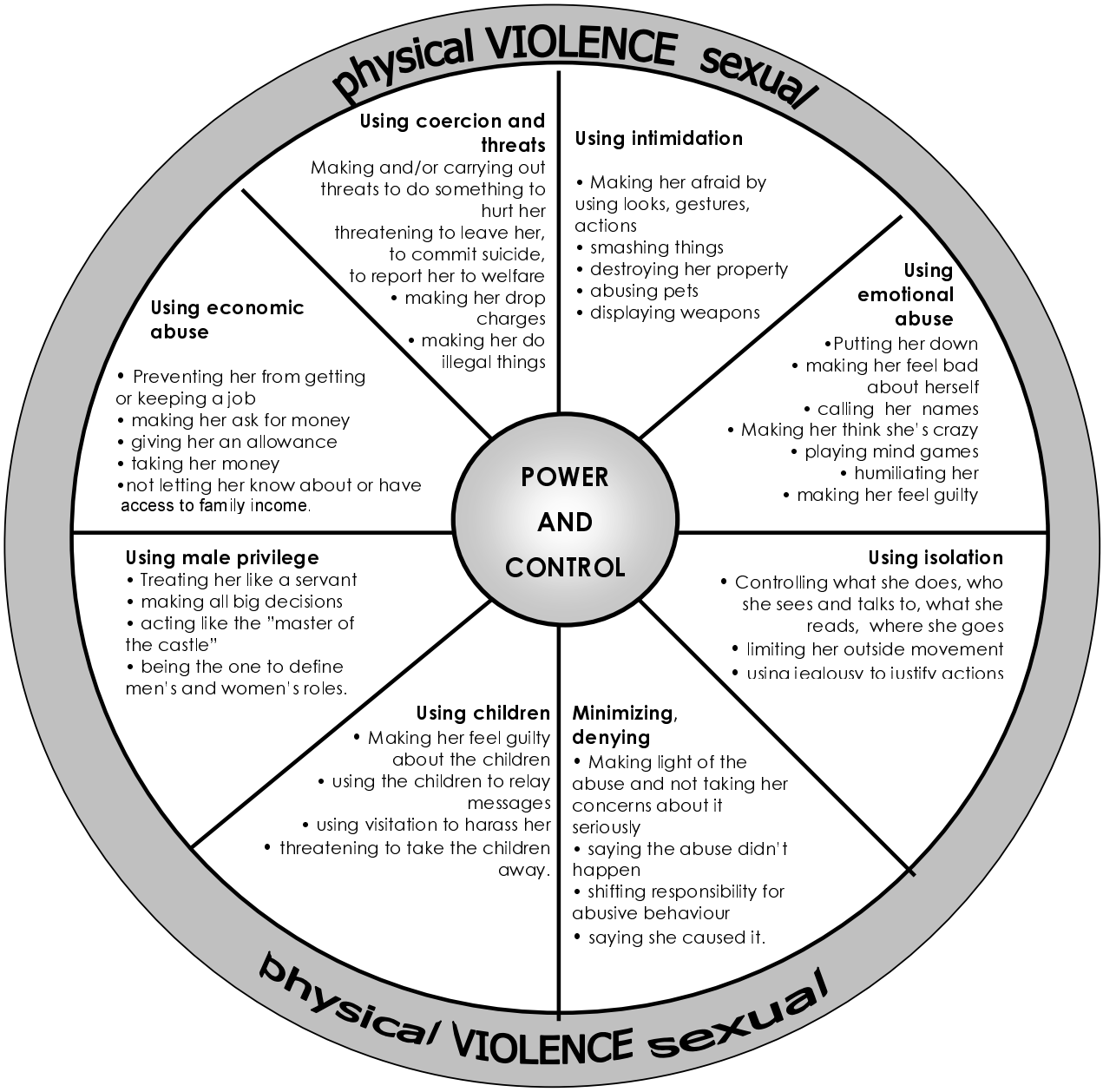
Use of power and control

Every emotionally and/or physically violent act increases the perpetrator's power and control over the victim. Power and control mean that the perpetrator constantly manipulates the actions, thoughts, emotions and beliefs of the victim by taking advantage of the intimacy of the relationship and feelings of solidarity of the victim. This decreases the victim's ability of thinking about the situation and acting independently. Power and control take many forms; there are visible as well as invisible forms (see Picture 1 "Power and Control wheel", page 15; Pence & Paymar 1993). The Equality Wheel (see Picture 2 "Equality wheel", page 16; Pence & Paymar 1993) shows what non-violence and equality in a relationship mean.

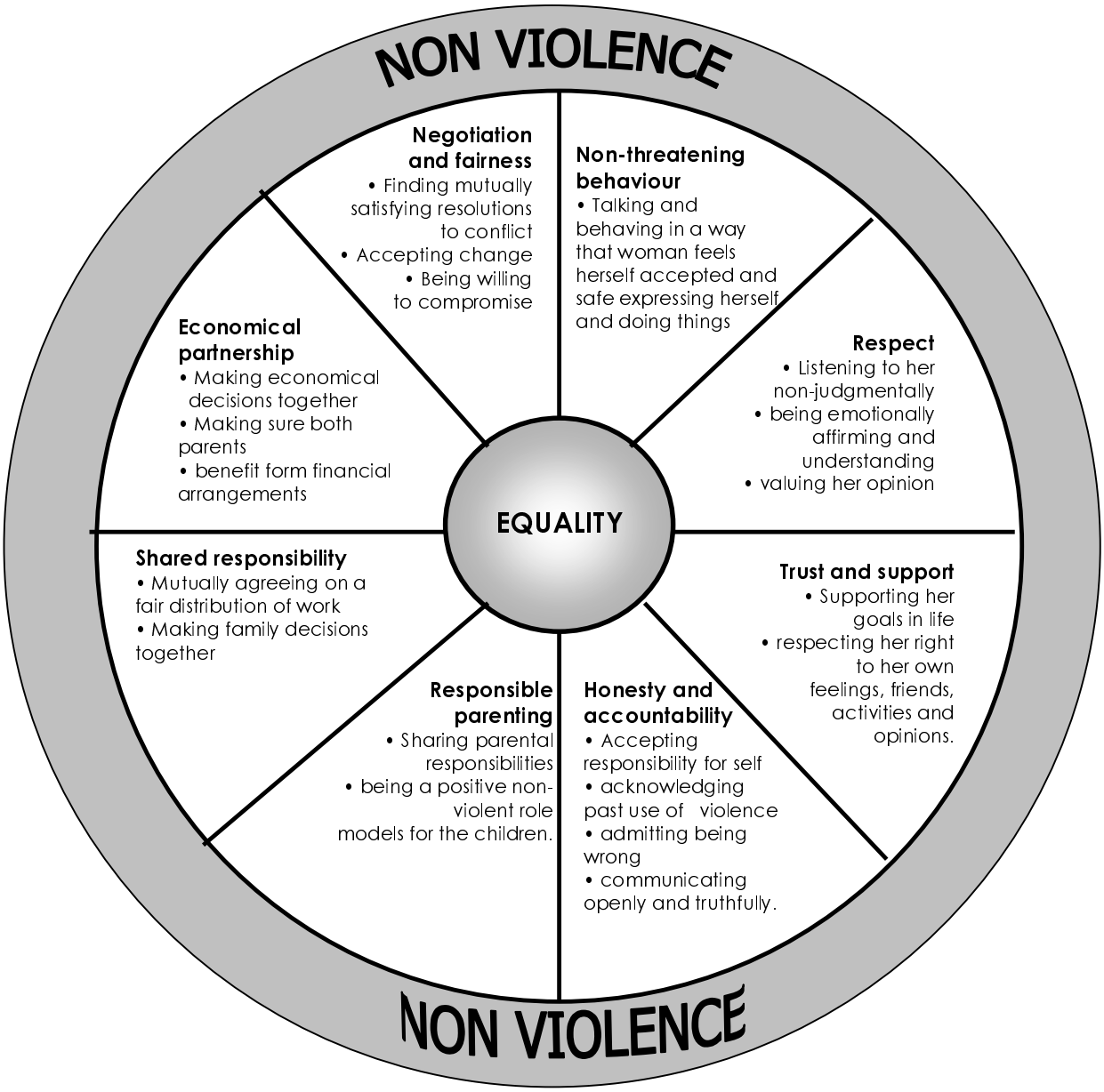
Cycle of violence

The cycle of violence (see Picture 3, page 17; Status of Women Council of the Northwest Territories 1995) means that there are periods of assaults and maltreatment and peaceful periods. The change between these periods is known in learning theories as intermittent reinforcement. In research it could be demonstrated that this model of behaviour produces emotional bonds and reduces the victim's ability to make decisions independently. The violent periods cause desperation and hopelessness whereas peaceful periods lead to relief and hope.

The Power and Control Wheel, Equality Wheel and Cycle of Violence can be useful tools when talking to the victim. They might help the victim to understand her situation better. The aim of supporting the victim is to empower her so that she can take her life into her own hands. This requires empathy and patience by the health professional because sometimes the empowering process can take a long time.



Source: Pence E. & Paymar M.(1993), Education Groups For Men Who Batter. The Duluth Model. Springer Publishing Company. New York.



Source: Pence E. & Paymar M. Education Groups For Men Who Batter. The Duluth Model. Springer Publishing Company. New York 1993.

CYCLE OF VIOLENCE

He minimizes his actions,
justifies his behaviour
DENYING
"if only she didn't …"

She blames herself

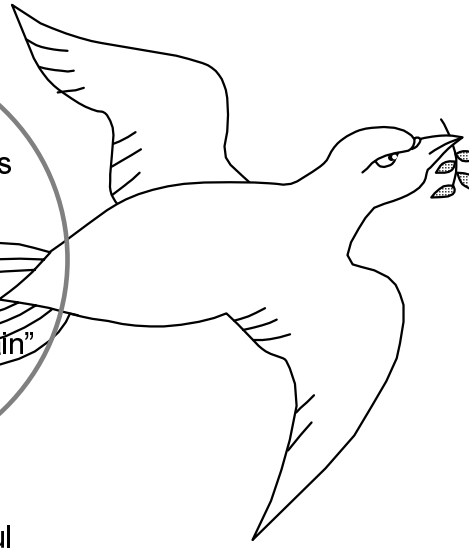
She feels pain and fear, she is
desperate and humiliated

EXPLOSION
ATTACK

TENSION GROWS

His behaviour gets more
and more aggressive
and threatening

He asks for forgiveness
"I love you"
"HONEYMOON"
ATMOSPHERE
"it will never happen again"



She is scared

She is hopeful
She feels that she is loved
She thinks she is in control

Source: Status of Women Council of the Northwest Territories (1995).

5 Addressing violence

Asking women if they are victims of violence perpetrated by their partner (or a person close to them) is a very difficult task – but a highly important one. As research has shown most women react positively to being asked about violence although they themselves would not start talking about it (Stenson et al. 2001 b; Bacchus et al. 2002; Perttu 2005; see Annex 2). Routine enquiries, best by using a standardised screening tool, are therefore an essential part of medical care for (pregnant) women in maternity and child health care.

General notes

Confidentiality

A confidential relationship between the health professional and the woman makes it easier for her to open up and to talk about intimate aspects of her relationship.

When working with migrant women a longer time might be needed to build a confidential relationship since cultural differences, like taboos, need to be understood and respected. Her talking about sleeping problems and worries can also reveal that she suffers from violence. If her language skills are too poor, confidentiality can be increased by calling in an external official female interpreter.

Jealousy

Many women talk about their partner's "jealousy" but actually they talk about violence, e.g. about attempts to limit their movements and to keep them from meeting her friends. Women may tell about their partners asking questions where they had been, who they had met and what they had being talking about. Men check calls or messages received on the mobile phone or by e-mail, they ask about colleagues and imply affairs at the work place. Women do not always experience their partners' jealous behaviour as restricting their lives.

Arguments

If violence only occurs in arguments, it is difficult for the women to distinguish between an argument and violence. In such situations women tend to feel responsible and try to change their behaviour without even noticing. They can, e.g., become hesitant to express their opinions, they soften their speech, limit their lives and movements and adapt in many other ways in order to avoid conflicts. At this point the cycle of violence and the adaptation process of the woman has already begun (see picture 3, page 17). It also influences the children's behaviour and the atmosphere in the family.

Alcohol/ism

It is also important to listen to women talking about their partners' behaviour under the influence of alcohol. Violent behaviour when drunk is often not taken very serious. It can be underestimated or even ignored. Abused women can just do the same. Violence is considered to be a temporary behaviour and is not paid any particular attention to. Being violent and having an alcohol problem are two problems which have to be treated separately.

Inquiring about intimate partner violence

Asking naturally about violence can be trained so that it becomes routine. By asking about violence a health professional demonstrates professional caring and attention to the well-being of women and children.

Principles for enquiring about violence

- The victim's and the child's safety is paramount: Always ask about violence when you are alone with the woman, do not ask when she is accompanied by her partner, sisters, daughters, friends etc.
- Focus all your attention on her (eye contact is important). Avoid doing paper work at the same time.
- Avoid positions that might be perceived as threatening when asking about violence: Sit at the same level or lower.
- Start by developing trust.
- Your understanding and accepting attitude will show the woman that you respect her.
- Take the initiative to ask about violence, do not wait for her to bring it up. This way you show her that you take a professional responsibility for her situation and by doing so you help to build trust.
- Ask about violence directly and in a friendly and warm way.
- When you talk about violence openly you set a good example that it is alright to talk about violence and that she is not the only one to experience violence.
- Do not react with shock when she discloses violence; your surprise will add to her feelings of isolation and belief that the violence she suffers is unique.
- Stress that spousal assault is a crime; do not blame the woman.
- If she has hearing/visual disorders, ask her to tell you how she could hear/see you best.
- Do not overlook disabled women. Disabled women are in a greater risk of becoming a victim of violence. Ask if anyone, her partner or a person taking care of her, has been violent against her.

Asking about violence:

- Use questions beginning with "How", "When", "Who".
- Supportive statements such as "I am sorry this has happened to you" or "You have really been through a lot" encourage her to disclose more information.
- Do not ask victim-blaming questions such as "Why do you stay with him?", "Why don't you just leave him?", "Did you have an argument before violence happened?"
- Try to change her attitudes relating to why violence happened like "I talk too much…" or "He only gets this way when he drinks". Emphasize the perpetrator's responsibility for his behaviour.
- Give her information about violence, e.g. its frequency and the dynamics.
- Talk about her personal resources and options for empowering her.
- Try to find adequate services together with her.
- Leave "the door" open for her to come back to you.

Examples for enquiring about violence

Starting questions:

- "From my experience I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?"
- "We know that abuse and violence at home affect many women and it impairs their health. I wonder if you have ever experienced violence at home?"
- "Have you ever felt unsafe or threatened in your own home?"
- "Has anyone ever hurt you?"

Questions when you suspect violence although she seems not to have any signs of physical violence:

- "According to my experience I know that violence at home is a problem that affects many women. Do you feel this problem touches your life in any way?"
- "We know that violence has a direct impact on many women's health. Therefore I ask you as well: Do you experience violence at home?"
- "Do you feel insecure or are you afraid at home?"

Questions when she has signs of physical violence:

- "What has happened to you? How has it happened, where and when?"
- "Has someone caused these injuries?"
- "The injuries you have suggest that someone hit you? Is that possible?"
- "Who has caused these injuries?"
- "The injuries you have seem to be caused by an assault. Is this possible?"
- "According to our experience women get these kinds of injuries often when assaulted. Who assaulted you?"

Questions when she has brought up violence herself:

Estimate her situation by using the screening tool on page 32 and possible changes in the perpetrator's violent behaviour by using the danger assessment form on page 28.

You can ask the following questions:

- "When have you experienced violence before?"
- "How often does violence happen?"
- "What seems to start the violence?" (If she thinks that her own behaviour has caused the violence, give her correct information so that she does no longer feel guilty and responsible).
- "How has the violence changed over time? Has it become more serious, does it happen more often than before?"
- "Has your partner frightened you and how? Has he threatened to kill you, to use a weapon? Has he used a weapon?"
- "Are you afraid of your partner? Do you fear for your and for your children's life?"

Recommendations in particular situations

She denies having been assaulted:

- Do not insist or pressure her.
- Tell her what made you think of violence.
- Explain to her that she can come back for further assistance if she ever finds herself in such a situation again.
- Do not think the issue is over and done with. You have done your duty but come back to it later/at the next appointment.
- Talk about your suspicion in your team.
- Document your suspicion and what evidence it is based on.

She is intoxicated (alcohol, drugs):

- Minimize talking.
- Provide support and allow her time to recover in your unit/hospital before attempting to talk to her.
- Make sure that her phone number is in your files: you or your social worker can phone her later (during next 1-3 days).

She is hostile/abusive:

- Respect her anger. Anger is often a consequence of trauma and burn-out caused by violence. Women may have also failed in getting help e.g. due to inadequate responses of professionals.
- Offer support/services but do not insist or pressure her.

She just wants to leave as soon as possible:

- Make sure that her phone number is in your files: you (or your social worker) can phone her later (during the next 1-3 days). Mind the safety issues!

She is seriously ill or hallucinating:

- Allow her to stabilize before interviewing her.

You do not understand her due to language barriers:

- Ask for an official interpreter (the interview can be done by phone as well).
- The interpreter must not be the woman's husband/partner, child, other relative, friend etc.
- Use only a female interpreter (Hotch et al. 1995).

Other recommendations:

- A health professional's most important task is to listen to the woman's experience and assure her that her feelings are justified. It is also the health professional's role to make the woman accept the reality.
- Show that you believe her story and what has happened to her. Passive listening and non-commenting makes her doubtful as to what has happened and can make her think that she is wrong and the others are right, including the perpetrator.
- In addition to physical and sexual violence it is important to pay attention to psychological violence and to the abuser's use of power and control. The health professional's role is to support the woman to become aware of how matters are.
- Ask and listen to her previous experiences of seeking help. In case she has had bad experiences with public authorities and other help providers you do not have to defend and excuse them.
- Tell her about the impact of violence on victims (e.g. about burnout, impacts on physical health).
- Discuss beliefs related to violence. Give information on the facts: prevalence of violence against women, a woman is neither guilty of nor responsible for the partner's violent behaviour, she cannot eliminate violence by changing herself or her behaviour, arguments and violence are two different things, an alcohol problem does neither explain nor justify violent behaviour.
- Advice and help the woman to see a doctor even if you only suspect physical

and/or sexual violence. Tell her that a doctor's statement is relevant for her legal protection.

- Estimate the victim's need for an immediate crisis or intervention visit at a psychologist or at a psychiatrist.
- Tell the woman about her legal protection.
  - Tell her that violence is a crime.
  - Tell her about crime/sexual crime laws and restriction orders.
  - Discuss reporting an offence if she has been physically or sexually assaulted.
- Tell her about the importance of collecting evidence: Doctors' statements, documents of health care and other professionals, answering machine tapes, SMS, e-mails, letters, the victims' diary etc. can be used as evidence.
- Tell her about services available which can offer support and assistance. Give her brochures and phone numbers. You can also make an appointment for her at one of the services available.
- Motivate the client to seek psychological help. An abused woman needs specific support in order to cope with the consequences of violence. If the perpetrator seeks/has sought help for himself, it is recommended that the victim seeks help somewhere else. It is important that the children get help as well. Children have a right to talk about their experiences without their parents being present.

6 Talking about the children

If a woman is a victim of intimate partner violence this always has an impact on the children, too (Jaffe et al. 1990). Moreover, if the mother is a victim the risk for the child/children to become victims of violence increases considerably (Ross 1996). Some violent partners abuse the children as well (Bowker et al. 1998). Therefore it is important to ask if the partner has been violent against the children, directly, through threats or by having the children to witness violence perpetrated against their mother. The mother should also be asked if she is afraid of becoming violent against her children. Stress and trauma caused by violence can lead to impatience of the children and increase the risk of violent behaviour against the children from the mother's side.

Having this in mind it is important to talk about the child/children, about how they are and how they react to the situation in the family. Even if the children were not directly affected by physical violence, witnessing violent behaviour and acts of violence is psychological violence against the children. Violence against the mother can decrease her parenting abilities and family skills and can lead to neglect and maltreatment of the children.

It is important to support the mother's parenting abilities and to try to reduce her fear of losing the child/children. The mother should be encouraged and assisted to collaborate with child protection services. You can, e.g., consult a child protection worker together with the mother. In any way, the mother should receive information about child protection laws, what they mean in her situation and how a social worker can support her and her children. It is also important to tell the mother that by protecting and helping herself she helps and protects her children as well.

Some recommendations on dealing with issues concerning children:

- Talk about the impact of violence on children. Stress that children are also affected even if they do not experience physical violence.
- Be precise with facts. Talk about violence and children in such a way that you do not blame her for not being capable of protecting her children. Each violent act perpetrated by her partner against her increases the children's risk of becoming victims themselves.
- Think about and discuss with her how the children can be best protected, e.g., you can write a report for the child protection worker together with her.
- Talk about her worries and fears how to help the children. She can be afraid of losing her children. The violent partner has probably already threatened her that she will lose the custody of children if public authorities find out because she is a poor mother and. Threatening that the children will be taken away is one of the most common ways to make women remain in a violent partnership.
- Discuss the services available for children who have experienced violence. Explain to the mother that it is important for the children to talk about their experiences without their parents being present.

7 Safety

If a woman tells you that she is a victim of intimate partner violence it is vital to talk about her safety and the dangerousness of the perpetrator. A good practice is to prepare a written safety plan (see page 29) which you can give to her. It reinforces the mother's and children's feeling of being in control of the situation. Some of the consequences of violence can also be alleviated or avoided by such a safety plan. No matter if a woman returns to the violent partner or is about to divorce/separate/move out, it is highly important to prepare a safety plan.

The following recommendations should help you to deal with safety issues:

Assess the situation:

- Discuss with her if she wants/needs to go to a women's refuge immediately (with her children).
- If there is no women's refuge (place) available, can she be admitted to a hospital or can she go to friends or relatives?
- If she does not want to go to a women's refuge, give her written information about emergency numbers, women's counselling centres and other services.
- Ask her to keep the information at a safe place where the perpetrator cannot find it.
- Does she need immediate medical intervention?
- If she wants to return to her partner, give her a follow-up appointment.
- Talk to her about her legal rights and options (e.g. restriction order, report to the police).
- Encourage her to talk about the violence to someone who can give support if needed.

Protection issues

Staying in a women's refuge can be safer than staying with relatives or friends.

If there is no women's refuge in town find out other safe places (a crisis apartment or a ward at a hospital).

If a woman thinks that she can return home, recommend her to prepare a safety bag which she can hide somewhere (e.g. at a friend's or at a relative's home) for emergency situations.

A SAFETY BAG (see page 27) contains necessary things for her and for the children that make it possible to stay away from home for some days.

Estimating the fatality risk of violence

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

- History of the perpetrator's violence: Has the violent behaviour changed, has he been violent during pregnancy, has the man's father been violent against his wife and/or children, has the man a criminal record?
- What kind of violence was used (its frequency, gravity of injuries, mortally dangerous forms)?
- Has the perpetrator used guns or threatened to use them?

- Does he use drugs and alcohol?
- Does he show controlling behaviour (following and spying on her, controlling her movements, appointments and conversations)?
- Is he violent against children?
- Are there disagreements and arguments about the children?
- Does the woman want to separate / move out? The time of separation is the most dangerous time for the woman!
- Has he threatened to commit suicide? A perpetrator can commit "suicide" of the whole family.

In order to establish the dangerousness of a perpetrator the Danger assessment form can also be used (see page 28). If the form is used the woman must never be left alone to fill it in. You should go through the form together with the woman and talk about it. At the end the answers are evaluated together. Filling in the form is helpful also when taking/referring women and their children to a safe place like in a women's refuge.

Safety Planning

After having evaluated her situation and having estimated the dangerousness of the perpetrator it is important to draw up an individual safety plan together with the woman (see page 29).

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

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

If the battered woman has had the perpetrator evicted or/and is now living alone, evaluate the following options with her:

- Changing locks on doors and windows.
- If possible install a better security system – window bars, locks, better lights, fire extinguisher etc.
- Teaching the children to call the police or family and friends in a dangerous situation.
- Talking to teachers and child care providers about who has permission to pick up the children and developing other special provisions to protect the children.
- Finding women's support services knowledgeable about family violence to explore custody, child contact and divorce provisions that protect the children and the victim.
- Obtaining an injunction, barring order, etc. (depending on the legal situation).

If the client is leaving the perpetrator, review the following with her:

- How and when can she most safely leave? Does she have a means of transport? Money? A place to go?
- Is she comfortable calling the police if she needs them?
- Who will she tell or not tell about leaving?
- What can she and others do to prevent her partner from finding her?
- Who in her support network does she trust to protect her?
- How will she travel safely to and from work and school or pick up the children?
- What community/legal resources will help her to feel safer? Write down their addresses and phone numbers!
- Does she know the number of the local women's refuge?
- What kind of custody and child contact arrangements would keep her and the children safe?
- Would an injunction be a viable option?

If the woman is staying with the perpetrator, review the following with her:

- In an emergency what works best to keep her safe?
- Who can she call in a crisis situation?
- Would she call the police if the violence starts again? Is there a phone in the house/ does she have a mobile phone or can she work out a signal with the children or the neighbours to call the police or get help?
- If she needs to escape temporarily, where can she go? Help her think through several places where she can go to in a crisis situation. Write down the addresses and phone numbers.
- If she needs to escape, which are the escape routes from the house?
- If there are weapons in the house, explore ways to have them removed.
- Remind her that in the middle of a violent incident, it is always best for her to trust her own judgement about what to do – sometimes it is best to run away, sometimes to calm the perpetrator - anything that helps to protect her.

In any case she should have a safety bag ready.

Safety Bag

It should contain:

- some cash, mobile phone or a phone card and important telephone numbers
- extra pair of keys (home, car)
- official documents (marriage certificate, divorce papers, court documents, driving license etc.)
- passport and birth certificate (original or copies)
- social security card(s)
- welfare and immigration documents
- bank and credit cards, savings books
- medication and prescriptions
- extra clothes
- items for personal hygiene
- favourite toys of the children

Danger Assessment Form

Caution: Fill this in always together with the woman and discuss with her afterwards what her answers mean in her situation.

In the your diary , please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how long each incident lasted in approximate hours and rate the incident according to the following scale:

1 Slapping, pushing; no injuries and/or lasting pain;
2 Punching, kicking, bruises, cuts and/or continuing pain;
3 "Beating up", severe contusions, burns, broken bones;
4 Threat to use weapon; head injury, internal injury, permanent injury;
5 Use of weapon, wounds from weapon.
(If any of the descriptions for the higher number apply, use the higher number.)

Answer these questions yes or no.

1 Has the physical violence increased in frequency during the past year? _____
2 Has the physical violence increased in severity during the past year, and/ or has a weapon or threat with weapon been used? _____
3 Does he ever try to choke you? _____
4 Is there a gun in the house? _____
5 Has he ever forced you into sex when you did not want to have sex? _____
6 Does he use drugs? _____
7 Does he threaten to kill you and/or do you believe he is capable of killing you? _____
8 Is he drunk every day or almost every day? _____
9 Does he control most or all your daily activities? _____
10 Have you ever been beaten by him while you were pregnant? _____
(If never pregnant by him, check here____.)
11 Is he violently and constantly jealous of you? _____
12 Have you ever threatened or tried to commit suicide? _____
13 Has he ever threatened or tried to commit suicide? _____
14 Is he violent toward your children? _____
15 Is he violent outside the home? _____

_____ TOTAL YES ANSWERS

Source: Schornstein (1997), Domestic Violence and Health Care, Sage Publications.

Individual Safety Plan

Client _____ Health professional_____

Date _____ Re- evaluation (dates) _____

1 If my own or my children's safety is in danger at home, I can go to _____ or _____ or_____ (decide this although you would not expect another violent act anymore).

2 In a violent or threatening situation a safe way out is _____ (e.g. which doors, windows, elevator, stairs or emergency exit I could use).

3 I can talk about violence with the following persons and ask them to call the police if they hear suspicious noises in my house: _____ .

4 I can use (e.g. a sign, a word)_____ as a code with my children or friends so that they can call for help.

5 If my partner does not live with me anymore, I can ensure my safety at home (locks, keys, alarm system etc.) _____ .

6 I can keep my handbag/safety bag (a place at home/at a friend's home) _____ .

7 I need the following things in case of a quick departure from home (content of the safety bag):
   - o money/cash
   - o extra pair of home and car keys
   - o extra clothes
   - o personal hygiene items
   - o mobile phone, important phone numbers, phone card
   - o medical prescriptions
   - o important documents/cards (health insurance card, identity card etc.)
   - o children's favourite toys
   - o other, _____

8 The health professional has told me that:
   o I am not responsible for the violent behaviour of my partner but I can decide how to improve my and my children's safety.
   o I deserve better than this: me and my children have the right to lead a safe life without fear.
   o Violence is a crime and I can report it to the police.
   o There are restriction/barring orders and I know how I can apply for them.
   o There are places where to get support: _____
   _____

9 The health professional has suggested/we have agreed that I can continue dealing with the problem at the following help providers: _____
   _____

10 Together with health professional I have made a (written) assessment of violence. In my situation these answers mean that _____
   _____

11 I can keep this safety plan without endangering my own or my children's safety at:
   _____

Source: Perttu S 2004.

8 Screening questionnaire

Most women do not disclose being victims of intimate partner violence to health professionals even though they most often seek help from them. Since the majority of health professionals do not ask about intimate partner violence most cases remain unnoticed (Bacchus et al. 2004 a). Screening questionnaires based on the experience of health professionals are helpful in asking about violence in intimate relationships and about violence against children. The screening questionnaire introduced in this guidebook is based on the Finnish researches (see the annex 3) and the Abuse Assessment Screen (AAS) (McFarlane and Parker 1994).

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

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

The screening questionnaire forms part of the medical examination. In cases of acute intimate partner violence the medical examination also includes documentation by using the Body Map and photographing (see Chapter 9).

Use of the screening questionnaire

It is important to pay great attention to the safety of women and children when enquiring about violence. It is vital to do the interview only when you are alone with your client. The presence of a potential assaulter/violent partner can put her in great danger of being abused again.

Sometimes it can be difficult to find time alone with the client, e.g. the violent partner wants to be constantly present and control the situation. The maternity and child care can develop a practise of having some visits without anybody else being present. For migrant women these kinds of visits alone with the health professional are even more important because their husbands can act as interpreters and there is no space for bringing up violence-related issues. Therefore the maternity and child health clinics should make sure that women come on their own by working together with external female interpreters.

The use of the screening questionnaire is just the beginning of the support process. It is important that there are other support services available and that the health professionals cooperate with them. It is essential to use the questionnaire routinely and with every woman in certain checkups (as agreed upon in one's own institution).

Instructions for the use of the screening questionnaire:

- Pose the questions with calm and in no hurry. Give the woman time to think about them and the possibility to ask further questions.
- You can go through the set of questions while talking. Yet, it is important that the same questions are asked in the same way. In order to do that the questions must be put (read) as they are on the form.

- Give practical examples by explaining what e.g. controlling behaviour means.
- Specify the questions if needed.
- You can write the victim's story on the back side of the screening form, e.g.:
- Document the victim's story by using her words and expressions.
- Documentation is important for her legal rights and her protection – she might need the documentation later if she wants to report to the police / go to court.
- The way you ask and write down the story is important.
- The woman has the right to read the form and to have a copy of it.

Examples of bringing up the violence when using the screening questionnaire:

"Here in our clinic we usually talk to women about their experiences in intimate relationships, in particular we ask about violence in a partnership. We do this because according to our experience partnership violence is common. We use a questionnaire and I will now ask you the questions that we have here."

"In maternity and child care it's important to follow the health and well-being of mother and children which are influenced by many factors. Violence is one of the factors that can threaten your and your children's health. That is why we have started to ask every mother/woman about intimate partnership violence. We use a questionnaire that has been developed especially for asking about violence."

"In maternity and child care it's important to discuss partnership and family matters. In our clinic we usually ask every client about partnership violence. We use a questionnaire that I am now going through with you. We can discuss these issues in more detail if you feel like it."

Intimate Partner Violence Screening in Maternity and Child Health Care Clinics

The following questions are intended for expectant mothers in their first or second trimester and for mothers with an infant no more than six months old and afterwards at the yearly check-ups.

WHEN ASKING THESE QUESTIONS, NO PERSON SHOULD BE PRESENT OTHER THAN THE INTERVIEWER AND INTERVIEWEE.

Circle the answers given by the interviewee.

Does your partner sometimes behave in a manner that makes you afraid of him?

1 yes
2 no

Does your partner behave in a derogatory, humiliating or controlling manner towards you?

1 yes
2 no

Has your current partner

Yes	No	
1	2	threatened you with violence (incl. threat to use a weapon/object)?
1	2	grabbed, pulled, pushed, slapped or kicked you?
1	2	used some other form of physical violence against you? If so, what? _____
1	2	pressurized, forced or attempted to force you into having sex?

When did your current partner behave violently?

Yes	No	
1	2	During the past 12 months
1	2	During pregnancy
1	2	After the child was born

Has your current partner been violent towards your child/children?

1 yes
2 no

Have any of your children been watching or listening when your partner has behaved violently?

1 yes
2 no

What type of support/help for your situation would you like?

Source: Perttu S 2004

9 Medical Examination

Careful medical examination promotes the victim's legal rights. The medical examination can be a stressful experience for the victim. It is important to do the examination with respect and protecting the woman's self-esteem. She can experience the examination as humiliating and can try to get out of the situation as quickly as possible. Careful medical examination includes photographing the injuries, the use of the Body Map and the documentation.

Principles for examining victims of violence:

- Explain the medical examination, what it includes, why it is done and how.
- Ask the woman's permission to do the examination: It helps her to feel that she has control over what happens to her.
- A calm and emphatic behaviour makes it easier for her to talk about what has happened.
- Examine the victim always without anybody else being present.
- Do not leave the victim alone (e.g. when she is waiting for the examination).
- Ask if she wishes a female doctor (especially if she has experienced sexual violence).
- Explain to her what is going to happen and why.
- Always examine the whole body.
- Examine all injuries – not just the worst ones or those in need of care.
- Examine especially the areas covered by clothes.
- Note location, severity and stage of healing of each injury or any area sensitive to pain (invisible!) and mark them on the Body Map.
- Asking about sexual violence:

  If you suspect sexual violence, do a gynaecological examination.

  Ask the victim's permission for this examination.

  Note all injuries/swellings/areas sensitive to pain in the genital and abdominal area.

  If the patient is a rape victim / victim of sexual violence examine the whole body, not just the genitals and the abdominal area.
- If you find it difficult to establish what caused the injuries, ask forensic help.
- Ask about substance abuse (alcohol, drugs) and document it.
- If the patient is drunk arrange a place for her to stay overnight. The next day you can better evaluate the psychological impact of the assault.
- Note possible contradictions between the injury and the explanation she gives. Clearly document this contradiction.
- Even if a victim does not explain an injury by violence it has to be documented if you suspect that it was caused by violence. But give reasons!
- Note emotional and psychological symptoms as well and document them.
- Note non-medical indications of violence, e.g. torn, damaged or bloodstained clothes, and document your observations.
- Give a copy of the medical statement to the patient if she asks for it.
- If the victim has been brought to the hospital by the police and she then provides new information during the examination, ask the police or her lawyer to interview the victim once more.
- If the victim is unconscious do all medical examinations which can benefit the victim's legal rights.
- In order to have the full description of the injuries give the victim a follow-up appointment 1-3 days later.

Photographing injuries

- Photographing injuries should be a standard part of the medical examination and the documentation. If she does not want to be photographed offer her the opportunity to come at a later time for doing it.
- Ask the victim's permission (a written form should be used if photographing is not a routine). Explain to her why the pictures are important (possible court hearing).

  Photographs can be used as evidence which supports the testimony of the victim in court.

  Photographs are fresh evidence and show the real situation after the assault. The legal proceedings can take place a long time after the assault; normally the injuries of the victim are healed by then and the perpetrator may play down his actions ("just self-defence").

  Photographs are immediate evidence: They can document the brutality of the assault, impact and seriousness of the injuries, the perpetrator's intention to kill, etc.
- Digital or instant cameras are recommended: There is no need to develop a film and one knows straight away whether or not the pictures have captured the desired image. The patient's identity information and the date can be put straight on to the photographs.
- Always take two pictures from each injury: one from the part of the body where the victim was wounded; the second should be a close shot of the injury.
- Use measuring tape or some other object like e.g. a coin to provide proof of the size of the injuries.
- Indicate the e.g. head-feet direction on the pictures.
- At least one photograph has to show the victim's face for purposes of identification.

The Body Map

The Body Map (see page 36) is a helpful tool to systematically document injuries.

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

Guidelines for documenting

- It is essential that any disclosure of violence will be documented. The documentation must comply with the current professional guidelines.
- Everything has to be documented accurately and in detail. Records may be essential, e.g. when the woman wants to prosecute or seek protection from the authorities. It is not necessary that the woman is already committed to e.g. report to the police. However, she may consider to do so in the future.
- Document carefully all current, healed and healing injuries discovered during the medical examination.
- Document carefully the victim's report using just her own words, expressions and phrases.
- Do not put leading questions or use your own interpretations (otherwise documentation loses its legal significance).
- Even if the victim is disordered, document her report by using her own words.
- Document all other observations (psychological symptoms, behavioural signs, etc.).

- Document the victim's statement of old injuries, their cause and date as well as the history of violence (the number of assaults, what kind of assaults etc).
- If it is legally possible, document the full name of the perpetrator and his relationship to the victim as provided by the victim.
- If a suspected false statement is given by the victim (after she is confronted), document the inconsistency of her statement in relation to the injuries observed.
- If the victim is unconscious or unable to make her statement for other reasons (shock), document her companion's statement and the possible inconsistency of his statement in relation to the injuries observed.
- Use non-judgmental terms in describing the victim's statement and behaviour (compare the next phrases):

  the patient claims…./the patient reports…;

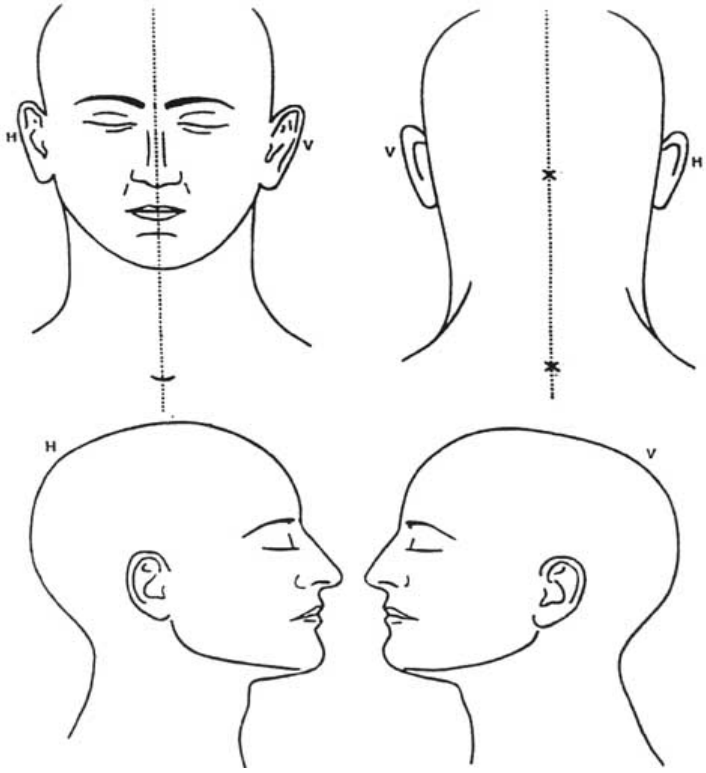
  the patient is hostile, uncooperative and intoxicated…/ the patient is exhausted, traumatized and unable to give full details at this time…

Name of the hospital

Address of the hospital

Phone/fax

BODY MAP



Name

Identification

EXAMINATION:

Date/time:_____

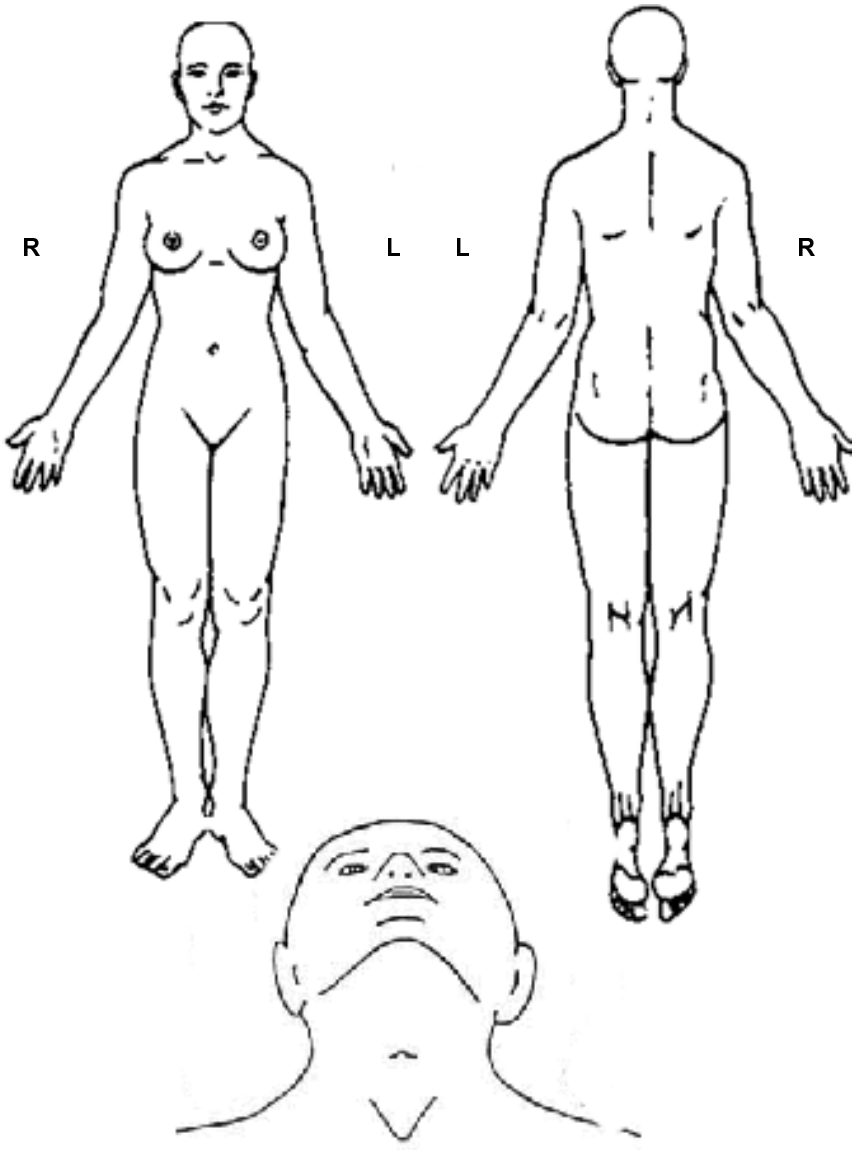
Doctor _____

Nurse _____

Photographs: yes _____ pieces no_____

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

x bruise
● black mark
O lump/swelling
▲ fracture / luxation
--- scratch
⊢ cut
/// pain



10 Multi-professional Co-operation

Co-ordinated collaboration and exchange of information between public authorities and other parties is essential in supporting a victim of violence and in trying to help the whole family. The collaboration manifests itself in common agreements about policies and actions, in clarifying responsibilities and duties of each party and in exchanging information. The responsibility for co-ordinating public authorities and other parties should lie on just one organisation. There should also be an agreement about secrecy and activities in order to build an open co-operation.

The process of multi-professional support

- Talk to the client and ask her permission to discuss her case in your team and/or local multi-professional working group. Ask her permission (written if needed) to collect information concerning her case if needed.
- If the client refuses to give permission, maintain contact with her and keep motivating her to get her case dealt with. She might be afraid that making her case public will put her in danger. Remember that she is the expert of her own situation.
- The laws relating to child protection may oblige you to collaborate with child protection authorities if the children experience violence or when the children live in conditions that endanger their well-being. Try to collaborate with the mother.
- Map out which other services, institutions or help providers are needed to support her and her family.
- Make a draft plan in your own team.
- Take the case to the local multi-professional working group (if it exists).
- The client (and her support person) can also participate in the working group meeting in which her case is dealt with.
- Agree on one person in the working group who is responsible for helping and co-ordinating activities.

Principles for co-operation

Safety:

In all prevention work the central task is to make sure that the activities of public authorities or other parties do not endanger the safety of the victim. Taking care of the safety of the woman means also protecting the children from violence and its harmful consequences.

Confidentiality:

It is important to offer the woman the possibility for a continuous communication with the help providers. This means that health professionals (and all others involved) must guarantee her complete confidentiality.

Individual support:

When talking with the client about the violence she has experienced you must emphasize that it is important for her to get specific help. This is important also for child protection issues – in order to be capable of protecting herself and children she needs support. Do not suggest discussions with the perpetrator – it can endanger her and her children's safety. All members of the family need individual support.

Children:

When a woman has children, a child protection worker can be consulted (check your legal situation) if the mother agrees. The mother should not be blamed for not being able to protect the children from violence. Women usually act in the best possible way in violent situations. However, in all cases use your own professional judgement: Evaluate the children's situation and if the danger is serious the child protection law may demand from you to act immediately.

Perpetrator:

One of the most demanding challenges of assisting a victim and her children is to get the perpetrator to seek help. Many abused women are concerned about how to help the perpetrator so that he will stop being violent. It is important to tell the woman that she is not responsible for helping her partner but that she can give him information about services available (e.g. perpetrator programmes). But you have to check if it is safe for the woman and children to pass on this information. You can also ask permission to contact someone else in the support system who will contact the perpetrator. Safety issues have to be very well considered in any case.

11 How to stay supportive

As a health professional it is important to recognize factors that influence one's own work. Being confronted with violence can challenge one's own professionalism from time to time. Patience and good skills to cope with stress are required from you. The work is emotionally difficult. Professional help providers may not be aware well enough of the traumatizing effect of violence on the victim. That is the reason why victims of violence can be experienced as difficult clients – passive and dependent, who always return to the violent partner. The help provider might get frustrated when despite good advice the victim does not take any action to change her life, separate from the partner, protect her children or report to the police.

Your work is influenced by several factors that should be recognised and kept in mind. The way of thinking follows prevailing attitudes, norms and values towards family, women, children and violence in society. It is important to go through one's own believes and stereotypes, the way of thinking and the prevailing attitudes in society towards family violence (alcoholism, mental diseases etc.) Prejudices against victims have an effect on your work, too. A health professional may think and experience that victims are not willing to talk about violence or are unable to make decisions. Lack of knowledge and experience can lead to thinking that the woman could simply leave the violent partner if she really wanted to or otherwise she is just a masochist (Schornstein 1997).

Feelings related to violence

Common feelings of help providers when working with victims of violence:

- You can be worried about the safety and well-being of the victim.
- You can be afraid of the perpetrator. You can be worried about the safety of your own family when perpetrators threaten you.
- You can be worried if your colleagues understand your feelings and support you.
- You can have feelings of anger caused by the behaviour of the victim or of the perpetrator.
- You can have feelings of hate towards society in general because life seems unfair. Working on violence prevention can change your perception of society which becomes a hostile place to live in.
- You can feel helpless and frustrated if the violence is going on and the victim comes again and again to ask for help, when the situation cannot be solved quickly, etc.
- You may overestimate your capacity and possibility to solve the situation.
- You may underestimate your possibilities to influence the situation.
- You may have conflicting feelings: hope, disappointment, depression, seeing but not knowing what to do, etc.
- You may have your own experiences of violence as a child and/or as an adult. How you have coped with the abuse affects how you work as a professional.

Working with violence, an ugly phenomenon of life, can lead to work trauma and exhaustion of the help provider. If you can talk about your thoughts, feelings and experiences in supervision, you will protect yourself and will be able to cope with difficult situations.

Training, supervision and other support for health professionals

Ways to maintain professionalism and well being:

KNOWLEDGE: It is important to know the causes and impacts of violence against women and children. How much you know influences your abilities to deal with situations arising in working with victims of violence.

It would be good to receive TRAINING before using the screening instruments. It is also valuable to get to know the most important facts about intimate partner violence by carefully studying material like this guidebook.

Before you start screening you should know the help system available in your area so that you can refer victims of violence and also discuss your work with experts from different fields (women's counsellors, social workers, police, justice, etc.).

You should work in a TEAM. Working alone is also a safety risk. As a health professional you should know where to get help in dangerous situations.

You should draw up a SAFETY plan for your work place because a violent partner can threaten you and your family with revenge. Working with a partner and/or in a team increases your safety. In case of immediate danger call the police. Health professionals should also have the possibility for getting support (e.g. being able to talk to somebody) after a violent situation.

Working with victims of violence should not be the task of a single person but shared in a group. If you feel like needing a break from working on violence, it should always be possible.

NETWORKING of public authorities and other parties: Violence issues require collaboration between different authorities and development of a network. By using networking as a method the knowledge and know-how of professionals from different fields can be utilized and that way the knowledge and well-being of everyone is also supported.

SUPERVISION: Possibility for supervision should be self-evident for everyone working in a caring profession, but it is especially important for those working with violence.

Possibility for CONSULTING: It is recommended that health professionals can turn to an experienced person in their own field or to a special expert of another field regarding specific questions like legal issues.

CONTINUOUS TRAINING: Help providers should receive special training on the methods in violence prevention in addition to their professional education.

SUFFICIENT REST AND FREE TIME: You need to have enough time to recover, otherwise the work load becomes intolerable. As a counterbalance to work, hobbies, positive experiences and good relationships are needed. It is easier to deal with problems of other people when one's own life is in balance.

Annex 1

Screening results in the partner countries

Estonia

Tartu Health Care Centre

Period of screening: May-June 2005

Conducted by: General Practitioner at her surgery

Results

The total number of women screened was 21. The number of positive cases (= women who had experienced IPV) was 5. The most frequent forms of violence were threatening, humiliating and controlling behaviour of the partner. One woman refused to answer.

Comments

Because the average age of the women seeing the GP was relatively high and many of them were divorced or widowed asking about violence in the current partnership could not reveal any information on the life-long experiences of violence. Health care centres' receptions and doctors' surgeries are therefore not the most suitable places where to apply the screening instrument used in this project. It seems to be more adequate for women in childbearing years, pregnant women and mothers of infants.

Finland

Screening was done in two different settings: in a hospital and in maternity and child health clinics which are part of the primary health care system in Finland. In addition, a survey on the midwives' and public health nurses' experiences in using the screening instrument was conducted in both settings.

Helsinki University Central Hospital/Women's Hospital/Department of Obstetrics and Gynaecology

Period of screening: March-May 2005

Conducted by: midwives

Results

Total number of women screened was 233. A high number of forms were left unanswered (146) although nobody refused to answer. The number of forms answered was 87. The number of positive cases was 8 (9 per cent). The most common form of violence was humiliating and controlling behaviour of the partner. Grabbing, pushing and kicking were experienced by four women. One had been a victim of physical violence during pregnancy. All women except one felt positive about being ask about violence; it was considered to be professional.

Comments

A big loss of completed questionnaires is due to the fact that women were not alone but often accompanied by their partners or children. Women who visited the Department of Obstetrics and Gynaecology had problems in their pregnancy and were therefore often accompanied by their partners. It is also a characteristic of Finland that fathers are encouraged to participate in the pregnancy from its early stage till checkups in child health clinics.

Asking about violence is not done routinely in Helsinki University Central Hospital, only if it is suspected that there might be a problem with violence. In those cases a standard screening form is used.

The Survey

A survey done by Rauni Kortesalmi, a midwife at a prenatal clinic, was conducted in spring 2005 asking midwives about their experiences in asking about violence. 21 questionnaires were sent to midwives whereof 14 answered.

The concerns of the midwives before starting the screening:

- Do I have enough skills to help victims of violence?
- How can I ask about violence in a natural manner?
- If a woman starts talking about violence do I have enough time for her?
- How do women react when they are asked about violence? In general, asking about difficult things makes me feel nervous.

The midwives reported that they were nervous at first but when the screening was going on they relaxed and felt that they had a professional right to ask. It was a kind of empowerment process for the midwives, too.

Some midwives felt that they somehow opened Pandora's box by asking about violence because then there was not enough time for talking about it.

The most difficult experience was the lack of time.

The best experience was that interviewed women were so positive about being asked.

Training: The training provided good basic knowledge about violence which was felt necessary for the screening.

Suitability of the screening tool in every day work: The Screening tool was found to be useful and suitable, clear and short enough. It made it easier to ask about violence. Midwives also felt that it is the midwives/hospital's responsibility to ask about violence, especially the responsibility of the primary health care (= Health care centres).

Vihti Municipal Health Centre

Period of screening: April-May 2005

Conducted by: midwives and public health nurses at six different maternity and child health clinics belonging to the Vihti Health Centre.

Results

The total number of women screened was 87. The number of positive cases was 7 (8 per cent). Nobody refused to answer. The most common form of violence was frightening, threatening and humiliating behaviour of the partner. Grabbing and pushing were also common. Three women had experienced violence during pregnancy and four after the child was born.

All women except one felt it was good to bring up intimate partner violence issues when visiting mother and child health clinic.

Comments

In the Vihti mother and child health clinics the screening is already done routinely. At the beginning health professionals felt that it was a difficult task to ask about violence but in time it became more natural and nurses justified the screening by considering it important for the mother's and the child's health. The midwives noticed basically three problems: lack of time, presence of the partner and it felt a bit awkward to repeat questions about violence after a year if there were no signs of violence in the beginning.

The Survey

In the Vihti Municipal Health Centre a survey was conducted by two students of the Health Care Polytechnic (Marjo Sinkko and Kati Savolainen) as part of their thesis in May 2005. The aim was to study the public health nurses' experiences in asking about and recognizing violence and to assess their need for training in dealing with family violence in maternity and child health clinics. Nine public health nurses were asked to answer 12 open questions. All of them had used the screening instrument before. The nurses' experiences in using the screening tool can be summarised as follows:

The nurses considered it important to ask about violence. The mothers also considered it important no matter if they had experienced violence or not.

The picture that public health nurses had formed of the families (some they have known already for a long time) made it more difficult to ask about violence. The nurses felt asking about violence difficult if there had not been any problems in the family before.

More than half of the nurses thought that asking about violence was a normal part of the work in maternity and child health clinics. Many of the nurses were already experienced in asking about violence and some felt it was made easier with clear and specific questions. Generally, the more experienced nurses are the easier it is for them to ask about violence.

The screening tool was considered a good way to start a conversation about violence. It offered the possibility to discuss family violence and its harmful impact on children.

The nurses experienced most difficulties when positive signs of violence came up.

Greece

University of Crete, Faculty of Medicine, University General Hospital, Department of Obstetrics and Gynaecology, Heraklion

Period of screening: July-September 2005

Conducted by: doctors and midwives

Results

The total number of women screened was 101. The number of positive cases was 35. Nobody refused to answer. The most common form of violence was frightening and controlling behaviour of the partner. Two women had experienced violence during pregnancy. Nearly all women felt embarrassed and awkward when they were asked about violence. The majority of women who stated not having experienced violence felt uncomfortable or indifferent to the questions. Only eight women expressed positive feelings on being asked about violence.

Comments

The results may be an indication for the Greek culture which makes it difficult to address domestic violence issues. Women feel it is a family matter which they do not want to expose in public.

Before receiving training five doctors of the Crete University Hospital were asked about their attitudes on domestic/intimate partner violence. The most interesting findings were that the majority thought that abusers are violent in all their relationships, that therapy can stop the violent behaviour, and that domestic violence is just a family's private problem and the children should stay with their father even if he is violent.

Lithuania

Vilnius Maternity Hospital, Obstetric department

Period of screening: February-April 2005

Conducted by: midwives

Results

The total number of women screened was 104. The number of positive cases was 26. Nobody refused to answer. The most common forms of violence were frightening and controlling behaviour but also grabbing, kicking and forcing to have sex. Eight women had experienced violence during pregnancy and four after the child was born. The majority of women felt uneasy about answering the questions on violence.

Comments

In the Vilnius Maternity Hospital asking about violence has been going on for four years already. The more experienced midwives and nurses are in asking about violence, the more positive cases are revealed. This correlates with findings of studies in other countries. In Lithuania it is not easy for women to talk about violence with their family doctors because doctors often know the whole family (including the husband). Women find it difficult, dangerous and embarrassing to talk about this very sensitive matter.

Conclusion

The results show that there are cultural differences between the partner countries relating to violence in intimate partnerships and asking about it. Despite these cultural differences the screening questionnaire developed in the Finnish context seemed to work well in practice. However, the screening by most of the partners in this project was a short-term experiment and would need further testing.

ANNEX 2

Intimate partner violence and its screening at the maternity and child health clinics

The STAKES Programme for the Prevention of Prostitution and Violence against Women (1998-2002), funded by the Ministry of Social Affairs and Health, included a research project to identify a suitable method for identifying, addressing and discussing about the intimate partner violence experienced by women visiting the maternity and child health clinics. The project was carried out during the period 2000-2002 and included two surveys. Midwives and public-health nurses were given training and practical guidance in detecting and discussing partner violence. It was intended that the set of screening questions developed in the project would be introduced at maternity and child health clinics throughout the country as a pilot result. The idea for the project was based on the results of a Statistics Finland questionnaire survey of a random sample (Heiskanen & Piispa 1998). The survey revealed that young women in a relationship and women with children under seven years of age were more often the subjects of partner violence than other age groups of women.

The first study was carried out in 2000 at prenatal and mother-child clinics located in Vantaa and Porvoo in Southern Finland and in the Palokka health care federation of municipalities in Central Finland (four municipalities). The study design involved structured questionnaire interviews conducted by public-health nurses and midwives among pregnant women and mothers with infants. At the time of the interview, their youngest child was one year old or younger.

In Vantaa, material was compiled between 1 May and 31 December 2000, while in Porvoo and the Palokka health care federation the period was between 1 September and 31 December 2000. To reinforce trust and security among women, the interviewer was always the client's personal public-health nurse or midwife, whom the client had visited at least once before at the clinic. For the benefit of the mothers' and children's safety, the interviews were conducted with the mother present only.

The study aimed to examine the prevalence and characteristics of violence in relationships experienced by women who were prenatal and mother-child clinic clients during pregnancy and when their children were small. Another goal was to support public-health nurses and midwives in their efforts to recognise abuse victims as well as to encourage them to bring up the subject of violence in relationships. In the study, spousal abuse was defined as threats of violence and acts of physical and sexual violence. An 8-section set of questions was asked concerning abuse. The interviews also investigated male controlling behaviour, which meant behaviours to overpower, isolate and intimidate women. Controlling tendencies were asked through a 14-part set of questions.

The first survey

A total of 1,020 women were interviewed in the first survey in 2000. Each woman was interviewed once during the material collecting period. Five women declined to participate in the interview. Over half (56 per cent) of the interviewees were prenatal clinic clients and the remainder (44per cent) were mother-child clinic clients. Their mean age was 29.5 years. Of them, 57.4 per cent were married, over a third (38.1 per cent) were in common-law relationships, while 3.5 per cent were single. Most women (73.4 per cent) had children (totalling 898; 79.6 per cent were aged 0–6 years). A quarter (26.6 per cent, n=270) were expecting their first baby. Over half (68.3 per cent) were on maternity or child care leave.

In this study, „victim" was defined as a woman who had experienced in her current relationship at least one of the forms of partner violence as specified in the questionnaire. Of the interviewees, 17.9 per cent had experienced physical or sexual violence or threats in their present relationship (17 per cent of prenatal clinic clients and 19 per cent of mother-child clinic clients). Physical abuse usually involved constraints on women's mobility, manhandling, pushing, slapping and violent threats. Young women were a risk group as potential victims. A quarter (25.0 per cent) of 18–24-year-old women had at some point been victims of physical or sexual abuse or threats by their current partner. Of the women expecting their first baby, 15.6 per cent had experienced violence in their current relationship.

Over a quarter (26.8 per cent) of men had manifested at least one of the form of controlling

behaviour as specified in the questionnaire. This behaviour was usually associated with physical or sexual abuse or threats. Of the men having resorted to violence, 74.9 per cent had also acted in a manner degrading or intimidating the partner or tried to isolate her. Name-calling, intimidation and jealousy were common. Also among non-violent men, 15.7 per cent manifested some tendency to control their partner.

Male controlling behaviour increased the risk of physical and sexual violence or threats. Intimidation increased the risk over tenfold (risk ratio 10.7; p-value 0.0001), overpowering behaviour increased the risk sevenfold (risk ratio 7.36; p-value 0.0001) while tendencies to isolate more than doubled the risk (risk ratio 2.59; p-value 0.0001).

The women who had faced in their present relationship at least one form of partner violence as specified in the questionnaire were requested to answer further questions. Of them, almost a hundred (n = 99.54 %) women volunteered for more detailed interviews. Participation in that further interview was voluntary. Those having declined a more detailed interview explained that the abuse was not serious but a passing phase, which would not recur or violence was just some quarrel or conflict situation where the partner had lost his temper and acted violently.

The women given more detailed interviews had a relatively short history of spousal abuse, a fifth (21.4 %) had faced violence for less than a year and about half (41.8 %) had experienced violence for less than five years. Most women in this group (77.3 %) had been victimised during pregnancy as well and 17 per cent reported that abuse had started during pregnancy. This abuse (during pregnancy) usually involved physical violence. If the violent behaviour had begun during pregnancy, the women explained it by the spouse's jealousy or drunkenness. Another explanation given was the woman's own behaviour, such as "I didn't pay enough attention to him" or "He was ignored". If abuse had started before pregnancy, male violent behaviour usually continued during it as well.

Two thirds (66 %) of the participants in the further interview (n = 99) mentioned a symptom caused by the violence. Abuse had usually caused the women anxiety or irritation (36.7 %), depression (31.6 %), fear (29.9 %) and anger (26.5 %). A third believed that their children had seen or heard violent clashes in the family. Most of them reported that violence had not affected their children, while a fifth considered it to have caused distress: the children were scared, timid, aggressive or had difficulty adjusting to day-care centre or school.

Of the participants in the further interview (n = 99), 17.4 % had sought help from a health centre or doctor, 11.2 % from the police and 11.2 % from the social welfare authorities. All in all, a third (34 per cent) had sought help from the authorities and 15 % of violent men had done the same. Of the women, 70.4 per cent had told a close person, most often their mother, about their situation, while a third (29.6 per cent) had not informed anybody about the violence.

All the interviewees (n = 1020) were also asked how they felt about answering these questions at prenatal and mother-child clinics. In general, the participants had a positive attitude towards questions about violence in intimate relationships. They considered it important that health professionals at prenatal and mother-child clinics took the initiative and asked about possible abuse. In addition, public-health nurses and midwives regarded the issue as significant. Violence in the family jeopardises the child's development and may undermine parenthood. Consequently, the detection of such violence is a key aspect of the work done by the clinics.

The second survey

In the second survey in 2002, the number of women interviewed was 510. The aim of this survey was to get more information on violence during pregnancy and after the delivery when the child is under one year old. All the interviewed women were asked about violence during pregnancy and when their children were small; the youngest child being under one-year-old. The second research was conducted in the same prenatal and mother-child clinics as the first one but the interviewees were different.

Eleven per cent (n=55) of these women had been victims of physical or sexual violence or threat of violence at some point during their pregnancy. Seven per cent (n=35) of them said to have experienced violence during another pregnancy, three per cent (n=15) during the current pregnancy and one per cent (n=5) both during previous and current pregnancies. The majority (76 %) of assaulters were current husbands or common-law husbands. A fifth of assaulters were ex-husbands or ex

common-law husbands and four per cent were current or ex-boyfriends. A third of women had experienced violence during their pregnancy which was directed towards head, a third had experienced violence towards upper body and arms and a tenth of women had experienced violence towards their belly, another tenth towards the whole body and six per cent towards lower body and legs.

Eleven per cent (n=43) of women who had given birth (n=384) had been a victim of violence at some stage during their infant's first year. In 72 % of cases the assaulter was the current husband or common-law husband and in more than a quarter of cases assaulters were ex-husbands and ex-common-law husbands. A third of the women told that the violence was directed towards the head area, a quarter to upper body and arms and a fifth to the whole body. The violence experienced by these women during pregnancy and during their infant's first year was usually physical violence.

In the second survey 18 % of the women (n=510) had got some physical injuries, most of injuries were black marks and bruises. Women reported as impact of violence during pregnancy: miscarriage or threat of miscarriage (2,2 %), premature delivery or the threat of that (0,2 %), problems with the delivery or fear of delivery (0,2 %). One per cent of the women had started to use sleeping pills or other medication because of the violence and 1 % of the women victims had started to drink more alcohol during pregnancy.

The screening questionnaire

On the basis of the research results and project experience, and with reference to the Abuse Assessment Screen (AAS) developed in the United States, a partner violence screening questionnaire was drawn up in autumn 2002. Guidelines were also drafted for detecting partner violence and discussing the subject, and for contacting the authorities.

A number of conclusions were drawn from the project's two surveys. FIRSTLY, it is important to identify partner violence risk groups at the maternity and child welfare clinics and to develop various support measures especially for young expectant mothers and for mothers of infants, and to provide them with information on partner violence and its effects.

SECONDLY, it is essential that the women have the opportunity to discuss their own experiences of the relationship. Discussion of male control-related behaviour allows the opportunity to detect partner violence and to discuss it at an early stage.

THIRDLY, questioning about partner violence should be made a regular part of the work of maternity and child welfare clinics and should be included in their monitoring programmes. All women should be asked about partner violence using a standardized questionnaire form.

The Ministry of Social Affairs and Health in Finland recommends that maternity clinics ask about partner violence at least once during the first two trimesters of the pregnancy, and child health clinics no later than at the child's six-month examination and subsequently at the child's annual examinations by using the partner violence screening questionnaire developed in the research project.

Source: Perttu Sirkka (2004), Reports of the Ministry of Social Affairs and Health, ISSN 1236-2115; 2004:6.Helsinki, Finland (in Finnish).

ANNEX 3

Measurement instruments previously used for the assessment of violence

Instruments and research projects	Description of measurement instrument and assessment results
ISA (Index of Spouse Abuse) Hudson / McIntosh 1981; Mc Farlane et al. 1992.	Measures gravity and magnitude of physical violence of a male partner towards a woman and non-physical violence. Instrument contains 30 violent acts. Non-physical violence reported by women themselves contains e.g. the following: he hurts and embarrasses the woman in the presence of other people, shouts at her, demands her to obey his caprices, acts as if she were his personal servant, is mean in giving her money for housekeeping.
TSC-33 (Trauma Symptom Checklist) Straus 1979; Briere / Runtz 1989; Hedin / Janson 1999.	Measures especially long-term consequences of trauma caused by violence in childhood. TSC-33 contains five items: Dissociation, anxiety, depression, sleeping disorders and consequences of sexual violence (e.g. sexual problems). The TSC-33 instrument has demonstrated that there is a slight correlation to physical violence experienced during the past year (Hedin and Janson 1999).
SVAWS (Severity of Violence Against Women Scale) Marshall 1992; Hedin and Janson 1999.	Measures the quantity and gravity of threats and physical and sexual violence. It contains the following items: symbolic violence (e.g. kicking door or wall, throwing an object at her), threatening with minor violence (e.g. shake one's fists, frightening gestures and expressions), threatening with semi-serious violence (e.g. destroying her personal objects, threatening to harm someone dear to her) and threatening with serious violence (e.g. threatening to kill her or himself); slight physical violence (e.g. shaking her, grabbing her), minor physical violence (e.g. scratching, pulling her hair), semi-serious physical violence (e.g. hitting the face and head) and serious physical violence (e.g. strangling, burning with something); sexual violence (demanding sex although she does not want it, physical intimidation to sex, using some object in the physical intercourse). Instrument contains 46 violent acts in all.
PMWI (Psychological Maltreatment of Women Inventory) Tolman 1989; Hedin / Janson 1999.	Measures psychological violence of male partners towards women. Tolman (1989) developed the instrument from CTS and ISA. It contains two items: domination-isolation and mental-verbal violence. Domination-isolation describes actions indicating male control, e.g., he jeers at her physical appearance, criticizes her housekeeping, controls her use of time, spends money without asking her opinion, behaves in a jealous or suspicious way towards her friends, accuses her of extra-marital relationships, limits her use of phone, limits her movements outside the home. Mental-verbal violence contains among others the following actions: he treats her as if she were stupid, says things to disparage her, calls her names, accuses her of being violent, he changes his mood unexpectedly. The descriptions of behaviour used in the PMWI cover violent acts towards women well. However, the instrument contains behaviour that can occur from time to time in most relationships such as shouting at each other (Tolman 1989).
AAS (Abuse Assessment Screen) McFarlane et al. 1992; McFarlane/ Parker 1994; Norton et al. 1995; Stenson et al. 2001a.	AAS contains five items. They measure the number of physical and sexual violent acts and fear of the perpetrator during the whole life span, during the past year and after pregnancy. The instrument also contains a body map where the injuries caused by violence can be marked. This instrument has proved to be reliable and sensible in recognizing violence (McFarlane et al. 1992). AAS should be complemented by items describing psychological violence (Stenson 2001a).
PVS (Partner Violence Screen) Feldhaus et al. 1997.	PVS consists of 3 questions addressing physical violence (1 question) and the woman's perception of her safety (2 questions). The researchers tested PVS's accuracy against ISA and CTS in two urban, hospital based emergency departments in Denver/USA. Conclusions: The sensitivity of PVS is suboptimal, questions about sexual violence should be added plus a direct question "Are you here today because of an injury or illness caused by partner violence?" Researchers also recommended that questions about partner abuse should not be restricted to current partners because past abuse is a risk factor for future injuries and abuse.

ANNEX 4

Prevalence and consequences of violence during and after pregnancy

Researcher(s), short title, year and country	Aim	Target group and data collection	Results
McFarlane et al. Assessing for abuse during pregnancy 1992 USA	To establish the connection between incidence, frequency and severity of physical violence during pregnancy in relation to the entry time into prenatal care.	691 women, interview with AAS during their first visit into prenatal services. In addition questions from CTS and ISA. Estimation of fatality risk for women who were victims of violence (Danger Assessment Form).	17 % had experienced physical or sexual violence during pregnancy. Women who had experienced violence delayed their visit to prenatal services until the last trimester twice as often as women who had not experienced violence.
Berenson et al. Perinatal morbidity associated with violence experienced by pregnant women 1994 USA	To study the connection between physical violence during pregnancy in relation to low birth weight.	32 women victims of violence during pregnancy and 352 women who had not experienced violence. Interview.	Women assaulted during pregnancy had twice as many premature deliveries and a double risk of getting uterus infections compared to women who denied being a victim of violence.
Gielen et al. Interpersonal conflict and physical violence during the childbearing year 1994 USA	To study frequency and severity of violence after delivery.	275 women. Interview three times during pregnancy and six months after delivery.	Moderate violence or serious violence was more frequent after delivery (25 % of women) than before delivery (19 % of women). Women who had experienced violence were higher educated and their partner had sometimes used drugs. Factors protecting women from violence were higher age and support from friends.
Stewart Incidence of postpartum abuse in women with a history of abuse during pregnancy 1994 Canada	To estimate the risk of becoming a victim of violence after delivery if women had been victims of violence during pregnancy.	30 women who had been victims of physical violence during pregnancy. Interview. Frequency of physical violence was assessed for the three months before pregnancy, once in each trimester of pregnancy and three months after delivery.	27 (out of 30) women reported all together 57 acts of violence in the 3-months period after delivery. The average frequency of violent acts increased significantly in the 3-months period after delivery compared with any other 3-months period. 16 women suffered from severe depression, 9 had some other psychiatric disorders. 14 women had got injuries after pregnancy that needed medical care.
Dye et al.Violence, pregnancy and birth outcome in Appalachia1995USA	To study the consequences of physical violence during pregnancy.	364 pregnant women. Medical documents related to delivery and to the period after delivery were examined. Interview.	15.9 % of women told to have been victims of violence during pregnancy. Abused women were more often teenagers, first time patients, they smoked more frequently and had more often foetus complications and foetal losses.

Gazmararian et al. The relationship between pregnancy intendedness and physical violence 1995 USA	To study the connection between physical violence and planned/unplanned pregnancies	12,612 women. Questionnaire study on physical violence 12 months before delivery and 3-6 months after delivery in four states in the US during 1990-1991.	Physical violence was found in 3.8 % – 6.9 % of cases depending on the state. Unplanned pregnancy increased the risk of being physical abused by one's partner by 4.1 times compared to women whose pregnancy was desired.
McFarlane et al. Physical abuse, smoking, and substance use during pregnancy 1996 USA	To study the impact of physical violence, smoking and alcohol/drugs on birth weight.	1,203 pregnant women. Interview with AAS during first and second visit in prenatal services and during the last trimester of pregnancy. Birth weight from documents.	16% of women were victims of physical violence, 30% smoked and 12% used alcohol/drugs during pregnancy. Physical violence and use of alcohol and other drugs caused a significant risk for low birth weight.
Saurel-Cubizolles et al. Violence conjugale après une naissance 1997 France	To estimate the prevalence of intimate partner violence during the 12 months after delivery.	Survey in three maternity units among primipara and secondipara women. Interview three days after delivery. Postal questionnaires 5 and 12 months after delivery. 706 women taking part.	4.1% of women experienced IPV after delivery. They reported a higher number of miscarriages, more frequent use of psychotropic drugs and suffered from depressive symptoms more often. Risk factors identified: unstable relationship, living separate, partner being unemployed. Age, level of education and profession were of no significant relevance. No correlation between violence against the mother and the health of the child. Conclusion: Many women victims of violence seek help from their gynaecologist or GP since they are aware of their psychological, psychosomatic, etc. problems. But they are seldom asked about
Grimstad et al. Abuse history and health risk behaviors in pregnancy 1998 Norway	To study the connection between previously experienced sexual violence/physical IPV and smoking/abuse of alcohol during pregnancy.	83 women who gave birth to a baby under 2500g and 92 women who had delivered a normal weight baby (at least 2500g). Interview.	26% of women had experienced sexual or physical violence. Low birth weight was not connected to violence. Women who were victims of violence smoked and used alcohol more often during pregnancy than women who had not experienced violence.
Campbell et al. Physical and non-physical partner abuse and other risk factors for low birth weight 1999 USA	To estimate the impact of intimate partnership violence on low birth weight.	1,004 women. Interview with modified AAS and ISA within 72 hours of delivery. Separate analyses of 252 full-term deliveries and of 326 premature deliveries.	Both physical and non-physical violence caused a risk for low birth weight in the cases were pregnancy was full-term but not in the cases were delivery was premature.
Cokkinides et al. Physical violence during pregnancy 1999 USA	To study the connection between physical violence 12 months before delivery and complications during pregnancy, birth weight and premature delivery.	6,143 women who had delivered a living baby in 1993-1995. Questionnaire study.	11 % of women had experienced physical violence. They had more caesarean sections and needed to be in hospital more often than on average before delivery because of renal infections, premature contractions or injuries caused by blows to the abdomen or by falling.

Renker Physical abuse, social support, self-care, and pregnancy outcomes of older adolescents 1999 USA	To estimate the consequences of physical violence during pregnancy.	139 women, interview. Documents of interviewees in prenatal services were studied.	22 % of women told to have experienced physical violence during pregnancy. Women who were victims of violence had more low birth weight deliveries, had significantly more miscarriages and used more drugs/alcohol and had three times more visits to prenatal services than other women.
Hedin and Janson The invisible wounds 1999 Sweden	To estimate the frequency of threats of violence and physical and sexual violence before and during pregnancy.	207 pregnant woman selected at random in three prenatal clinics in Gothenburg. Interview with standardised questionnaire (SVAW as one of them) about experiences of violence during the past year and during the current pregnancy.	24.5 % of women had been victims of threats of violence, physical or sexual violence in the past six months. 14.5 % had experienced psychological violence during their current pregnancy. 14.5 % had been threatened with mild violence, 2.9 % with moderate violence and 2.9 % with serious violence. 11 % had experienced mild, 4.3 % minor, 2.4 % moderate and 4.3% serious violence. 3.3 % had been a victim of sexual violence.
Goodwin et al. Pregnancy intendedness and physical abuse around the time of pregnancy 2000 USA	To study the connection between unplanned pregnancies and physical violence before and during pregnancy.	Questionnaire study in 14 states to 39,348 women who had delivered 2-6 months before.	Unplanned pregnancy increased the risk of being a victim of physical violence before and during pregnancy 2.5 times. The women who were victims of violence were more often younger than others, black, not married, less educated, lived in overcrowded conditions, arrived to prenatal services later and smoked during the last trimester of pregnancy more often than others.
Hedin and Janson Domestic violence in pregnancy. The prevalence of physical injuries, substance abuse, abortions and miscarriages 2000 Sweden	To study the connection between violence during pregnancy and physical injuries, use of alcohol, smoking and miscarriages and to compare socio-economic factors of women who were and were not victims of family violence.	207 women. Interview with SVAW during the first, second and last trimester of pregnancy in three prenatal clinics in Gothenburg.	30 women had experienced symbolic violence from their partner. 4.3 % had been victims of serious violence. Women who had experienced violence were significantly younger, had a lower income and were less educated and had more abortions than on average. There were no differences in smoking and use of alcohol compared to other women.
Hedin Postpartum, also a risk period for domestic violence 2000 Sweden	To estimate the prevalence of physical and sexual violence after delivery.	207 women. Questionnaire study by using SVAW on threatening with violence and physical and sexual violence during eight weeks after delivery.	32 women had been victims of threats of violence or of physical or sexual violence during an eight-week period after delivery. 22 of them stated that they have not suffered any violence before. Women who had experienced violence after pregnancy were older and more often married than the women who had experienced violence before or during pregnancy.

Stenson et al. The prevalence of violence investigated in a pregnant population in Sweden 2001a Sweden	To study violence experienced from the current partner or from another familiar member before and during pregnancy. Focus on physical violence.	1,038 women. Interview with AAS in prenatal clinics in Uppsala in 1997/1998. Interviews were done either three times (n=797), twice (n=195) or once (n=46) on average during the 15th and/or 34th weeks of pregnancy and/or 11 weeks after delivery.	19.4 % of women had experienced emotional, physical or sexual violence at some stage of their lives. 2.8 % told to have been a victim of physical violence during one year before pregnancy, during pregnancy or after delivery. Women who were victims of violence had more abortions and general health problems (gynaecologic diseases or operations, bronchitis, or asthma or had needed psychiatric care), more urinary infections during pregnancy and/or more premature births than women who had not experienced violence.
Hellbernd et al. Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung 2003 Germany	To estimate the prevalence of domestic violence.	806 face-to-face interviews with female patients aged 18-60 years at the Emergency Unit of the University Clinic Benjamin Franklin in Berlin.	Of those women who had experienced violence and had also become pregnant already 13,5% reported that they had been physically assaulted during their pregnancy.
Gloor et al. Frauen, Gesundheit und Gewalt im sozialen Nahraum 2004 Switzerland	To estimate the prevalence of domestic violence.	1,772 questionnaires, mainly sent by post and filled in by the patients themselves. Carried out at the Maternité Inselhof Triemli in Zurich.	8.5% of women who had been pregnant in the last 12 months before the survey indicated that they had experienced violence perpetrated by their partner as opposed to 7.3% who had not been pregnant during that time.
Perttu Intimate partner violence and its screening at the maternity and child health clinic 2004 Finland	To study the prevalence of intimate partner violence in the current relationship, during pregnancy and after delivery when the youngest child was under one year old.	1,020 women (in 2000) and 510 (in 2002) were interviewed by the midwifes and public health nurses in prenatal and ante-natal clinics in seven municipalities. The first survey was carried out in 2000, the second in 2002.	Results in 2000: 18 % of women had at some time experienced physical or sexual violence or threats of violence in their current relationship. The risk groups were women aged 18-24 or women in a common-law relationship who had children under the age of seven. Results in 2002: 11 % of women had been victims of physical or sexual violence or threats of violence at some point during their pregnancy, and 11 per cent at some stage during their infant's first year.
Molzan Turan et al. Violence against women around pregnancy: a study in Italy 2004 Italy	To evaluate the frequency of violence during pregnancy and after delivery; to identify risk factors.	352 women in the Maternity Hospital Trieste. Interviews by trained females using a standardised questionnaire; 2-3 days after birth face to face, 7 months after delivery by telephone.	Low frequency of IPV around pregnancy: 1.1 per cent of women had been victims of physical violence before (12 months) or during pregnancy, 2.3 % had experienced another form of violence (but not sexual violence). Risk factors: unplanned/unwanted pregnancy, young age, immigrants, 3 or more children, not married, with irregular job (also partner).

Bacchus et al. Prevalence of domestic violence when midwives routinely enquire in pregnancy 2004 a Great Britain	To assess the prevalence of domestic violence (DV) in pregnancy when midwives are trained to enquire about it routinely.	1561 women aged 16 and over between September 1998 and January 1999 at the maternity services of Guy's and St Thomas' NHS Hospital Trust in South London. Midwives were required to routinely enquiry about DV at booking, 34 weeks of gestation and postpartum (within 10 days) using a variation of AAS. 265 maternity notes were reviewed for the retrospective case note survey.	Prevalence of DV in pregnancy was 1.8 % at booking, 5.8 % at 34 weeks of gestation and 5.0 % at 10 days postpartum. 892 women were asked about domestic violence on at least one occasion, of whom 67 were asked twice and 19 three times. Of the 892 women interviewed on at least one occasion 22 (2.5%) reported domestic violence during current pregnancy. In the retrospective case note survey one (0.37 %) case of DV in pregnancy was identified. Conclusions: Routine enquiry for DV can increase the rate of detection in maternity settings, thereby providing an opportunity for women to access help early.
Bacchus et al. Domestic violence: Prevalence in pregnant women and associations with physical and psychological health 2004 b Great Britain	To examine the prevalence of domestic violence and its associations with obstetric complications and psychological health in women on antenatal and postnatal wards.	200 English speaking women aged 16 and over in an inner-London teaching hospital were interviewed between July 2001 and April 2002. AAS was used to assess for experiences of DV. Depression was assessed using the Edinburgh Postnatal Depression Scale (EPDS).	23.5 % of women had lifetime experience of DV, 3 % during the current pregnancy. Women with history of DV were significantly more likely to be single, separated or in non-cohabiting relationship and to have smoked in the year prior and/or during pregnancy. Higher EPDS scores were significantly associated with DV, single, separated or non-habiting status and obstetric complications. Both a history of DV and increased EPDS scores were significantly associated with obstetric complications after controlling for other known risk factors. Conclusions: DV is regarded as an important risk marker for the development of obstetric complications and depressive symptomatology.

Despite differences there are certain indicators for violence during pregnancy which were found by most studies. There is a higher risk for violence during pregnancy for women who live in poor social conditions, if the pregnancy is unplanned or not desired and for pregnant teenage girls (McFarlane et al. 1992, Dye et al. 1995; Gazmararian et al. 1995; Goodwin et al. 2000; Hedin and Janson 2000; Saurel-Cubizolles et al. 1997). Women exposed to violence during pregnancy have more often abortions, miscarriages, premature deliveries, different kinds of complications, general health problems and caesarean sections (Berenson et al. 1994; Dye et al. 1995; Cokkinides et al. 1999; Renker 1999; Hedin and Janson 2000; Stenson et al. 2001a; Saurel-Cubizolles et al. 1997).

Abused women come to mother and child health clinics in a later stage of pregnancy than the average (McFarlane et al. 1992; Goodwin et al. 2000). One explanation is that physical violence by the partner and the exercise of power and control can prevent women from coming to maternity welfare services (McFarlane et al. 1992).

Women who are victims of violence during their pregnancy smoke, use alcohol and other drugs more often than women who have not experienced any violence (Dye et al. 1995; McFarlane et al. 1996; Grimstad et al. 1998; Renker 1999; Goodwin et al. 2000).

There are no consistent results as to low birth weight. While some studies found a correlation between abuse and low birth weight (Mc Farlane et al. 1996, Renker 1999), others could not identify any connection (Grimstad et al. 1999).

Little is known as to the prevalence of violence in pregnancy in the German-speaking countries in Europe. No research has been done so far in Austria as it seems. (Correspondence of the authoress with Dr. Erika Baldaszti from the Ludwig Boltzmann Institute for Women's Health Research in April 2005).

Pregnancies due to rape and their consequences

Despite the comprehensiveness of the recent National Survey on Violence against Women, Enquête nationale – Les violences envers les femmes en France (Jaspard et al. 2003), based on 6970 telephone interviews conducted in 2000, there were no explicit questions on violence in pregnancy and after childbirth. The only data related is the number of pregnancies due to forced sexual contacts. 11.6% of women reporting having been raped got pregnant. One third of them were under the age of 18. Two thirds decided to have an abortion.

Estimates for pregnancies caused by rape lie between 5-18% (Heise 1994). In a German study carried out by Susanne Heynen in 2000 (based on interviews with 445 women) all women who were abused and raped by their partner and had children with him also had got pregnant through rape (Heynen 2003). They either delivered the child or had a miscarriage. However, having conceived a child through rape often leads to very ambivalent feelings towards this child. Women get torn between giving the child love and comfort which is expected of mothers and rejecting the baby. Usually, women do not allow themselves any negative feelings and do not talk to anybody about them. The mother-and-child relationship is often impeded for years, especially if the child is a boy since he is stronger associated with the perpetrator.

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Further reading

to be completed individually
(literature in native language)

List of services

to be completed individually

Examples:

Women's refuge network
Local women's refuge

Local women's counselling centre

Rape crisis centre
Rape crisis hotline

Women's health centre

Counselling centre for migrant women

Child protection authority

Men's counselling centre