

Domestic Violence & Child Abuse: Connections & Best Practices

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Family Violence

- Abuse - physical, emotional, sexual
- All forms of family violence tend to go together - child, wife & elder abuse
- Intergenerational Transmission or “Cycle of Violence” - biggest risk factor for being a perpetrator of family violence is experiencing as a child - observing or being a victim - b/c of Learning? Trauma? Stress?
- Historical trauma – indigenous peoples all over the world – connected with high rates of family violence

Family Violence

- Neglect more associated with poverty than abuse
- Child abuse more likely to be reported by health care professionals if families are poor & minority ethnicity (Newberger & DeVos '89; IOM report on health disparities '02)
- Biggest risk for elder abuse is history of violence on part of perpetrator rather than frailty of elder
- Verbally aggressive family - also more likely to be physically aggressive

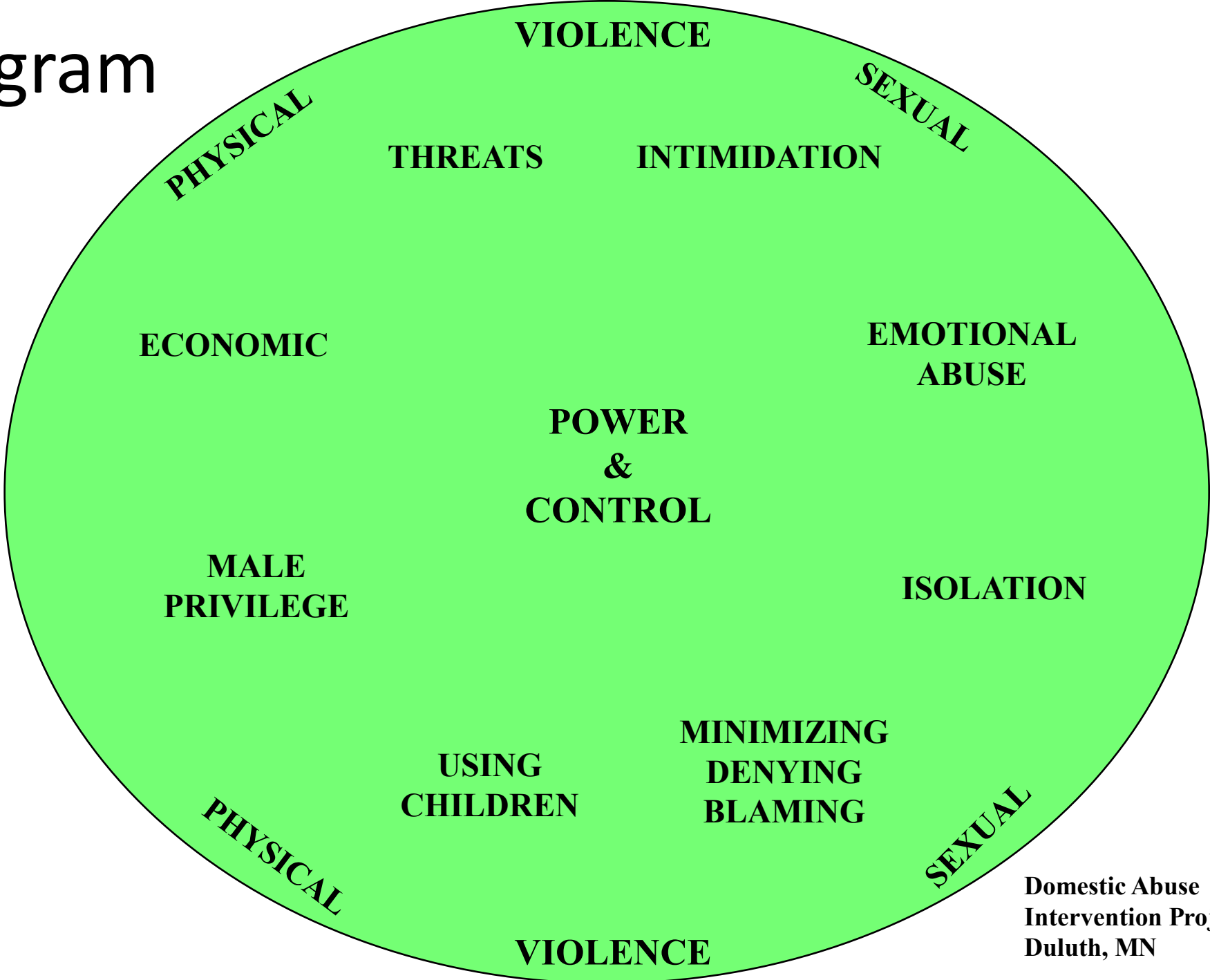
BATTERING

*REPEATED PHYSICAL AND/OR SEXUAL
ASSAULT WITHIN A CONTEXT OF COERCIVE
CONTROL*

(Campbell & Humphreys, '93)

Conceptualized as a risk factor for many health problems rather than a disease or syndrome or diagnosis

Diagram



**Domestic Abuse
Intervention Project
Duluth, MN**

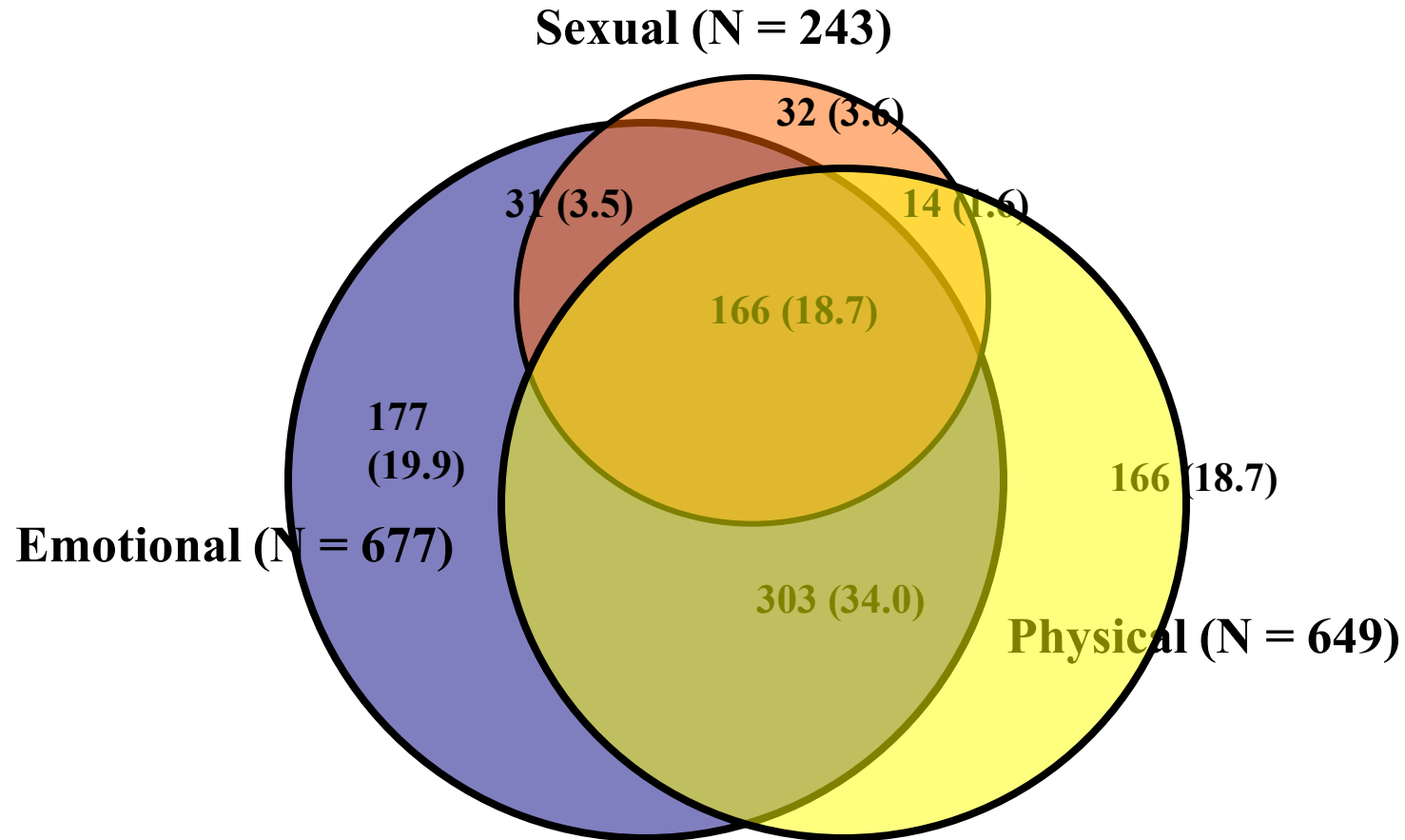
SEXUAL ABUSE

May include...

- Forced sex - by force or threat of force
- Painful sex - clearly indicated as unwanted
- Sexual degradation
- Sex without protection

Overlap between physical, sexual and emotional abuse (N = 889)

(Campbell et. al. '02 from Ellsberg '00)



DV: OVERALL PREVALENCE

- 4.4 Million US Women (Commonwealth Fund Surveys, 1996, '00)
- 8.4% any physical abuse in past year –
- Approximately same prevalence in MSM (Greenwood, Relf et. al. '03) – significantly less in female same sex partners T&T '01)
- 3.2% severely abused past year
- 52% injured (Bachman & Saltzman, 1995)
- 20 - 35% seek medical care or hospitalized (Brendtro & Bowker '89)
- 85% in the health care system for something (42% of femicide victims - Campbell et. al. '00)

PHYSICAL HEALTH EFFECTS

- Physical Injury (Facial, fractures, dental, neurological - soft tissue, internal, “falls” - Grisso ‘91)
- Neurological Sx - Coker ‘00, Diaz-Olavarietta ‘99
- Chronic Pain (Back, abdominal, chest, head) (Goldberg & Tomlanovich ‘85; Campbell ‘00; Coker ‘99); Fibromyalgia (Alexander et. al. ‘98; Walker et. al. ‘97)
- Chronic Irritable Bowel Syndrome (Drossman et. al. ‘90; Leserman et. al. ‘98)
- Hypertension (Rodriguez ‘89; Coker ‘99; Letourneau ‘99)
- Smoking (30% victims; 13% controls; Letourneau 99)

Health Effects - 5 Major Studies

(controlled, pop based or large HMO – Campbell et. al. '02; Coker et.al.'00; Leserman et.al.'98; McCauley et.al.'95; Plichta '96)

HEALTH PX/SX	p<.05	NS
Urinary Tract Infection	4	
Digestive Sx/Px (diarrhea, nausea)	3	
Bulemia, loss of appetite	2	
Pelvic pain	4	
Vaginal Infections	3	
STD's	2	
Painful intercourse, sexual dysfunction	3	

Health Effects - 5 Major Studies

(controlled, pop based or large HMO – Campbell et. al. 02; Coker et.al.'00; Leserman et.al.'98; McCauley et.al.'95; Plichta '96)

HEALTH PX/SX	p<.05	NS
General health or overall Sx	5	
Headaches, migraines	5	
Fainting, passing out	3	1
Seizures, convulsions	1	1
Back pain, chronic neck pain	4	1
Flu or cold, stuffy, runny nose	1	1
Hypertension	1	1

HEALTH EFFECTS OF FORCED RELATIONSHIP SEX

40-45% of physically abused women

INCREASED RISK OF:

- Unintended pregnancy (Campbell et. al., '96; Gazmararian et. al. '95; Goodwin et. al. '00)
- Adolescent Pregnancy (Berenson et. al. '92; Renker '99)
- Abortion (Evins & Chescheir 1996)
- Vaginal bleeding (Campbell et. al. '01)
- Anal & vaginal tearing (Campbell & Alford '89)
- Painful intercourse (Campbell & Alford 1989; Eby et. al., '95; Coker '00; Leserman '98)

HEALTH EFFECTS OF FORCED RELATIONSHIP SEX

Increased Risk of:

- STD's (Eby et. al. '95; Gielen et. al. '94; Coker '99)
- HIV/AIDS (Gielen et.al., '94, '00; Maman et.al. '00)
- Pelvic pain, Pelvic Inflammatory Disease, Infertility (Eby et.al. '95; Leserman '98; Schei '90)
- Urinary Tract Infections (Campbell & Alford '89; McCauley '95; Coker '99; Campbell et. al. '00)
- Risk of homicide, low self esteem (Campbell '89; '99)

Evidence of HIV/VAW Intersection

- US Longitudinal multicenter study - HIV negative & positive women – if past year or lifetime IPV - significantly more likely to report >1 HIV risk behavior (Cohen et. al. '00)
- Clinic study -HIV negative & positive women - women w/13 or > prior yr. abuse events – ½ as likely to use condoms vs. non-abused (Gielen et.al.'02).
- Clinic-study - women w/active STD & sexual abuse hx - more high risk sexual behavior vs. women w/active STD & no abuse hx (Chouaf '01).
- Qualitative studies - Near impossibility of negotiation of condom use with abusive partner (Champion & Shain '98; Davilla & Brackley '98; Chouaf et. al., in press; Stevens & Richards 98'; Zierler & Krieger '97)

HIV/ IPV CONNECTIONS

- Tanzania - 10X HIV+ rate if IPV (Maman '00)
- South Africa – prenatal patients more likely to be HIV+ if IPV (Duncan et. al., '04)
- US - HIV risk 26% amongst sexually coerced vs. 13% not (Choi '98) (N = 2030 - population based); (also Winwood & DiClemente '97)
- Rwanda - HIV + status associated w/ husband forcing sex & physical violence (Van der Straten '98)
- Reason for non-disclosure (75%) in Kenya - fear of IPV (Temmerman '95) - of those who disclosed 1/3 - beaten, abandoned or suicide
- Increased rates of HIV w/ DV –Zimbabwe-Watts et.al.'97

HIV/DV Connections – Etiology (Maman et. al. '99)

- Immune system depression with stress
- Trauma increasing HIV transmission; anal sex
- Increased STD's & untreated STD's (Letourneau '99; Coker et.al. '00; King et. al. '00)
- Impossible to negotiate safe sex if a battering relationship
- Women accused of infidelity if want to use safe sex
- Males have other partners unknown to women
- Fear of being beaten for being tested; notifying partner of positive status; delay in treatment
- Substance abuse

IMMUNE SYSTEM EFFECTS

- HPA axis – hypothalamic – pituitary – adrenal gland interactions
- Stress of abuse, multiplied by poverty, other stressors – but even separate from other stressors -activates HPA & produces corticosteroids & catecholamines
- Suppresses T1 cell or T1 cytokine (fights bacteria & viruses) production
- Depression has same effects on immune system
- Results in lowered immunity to HIV

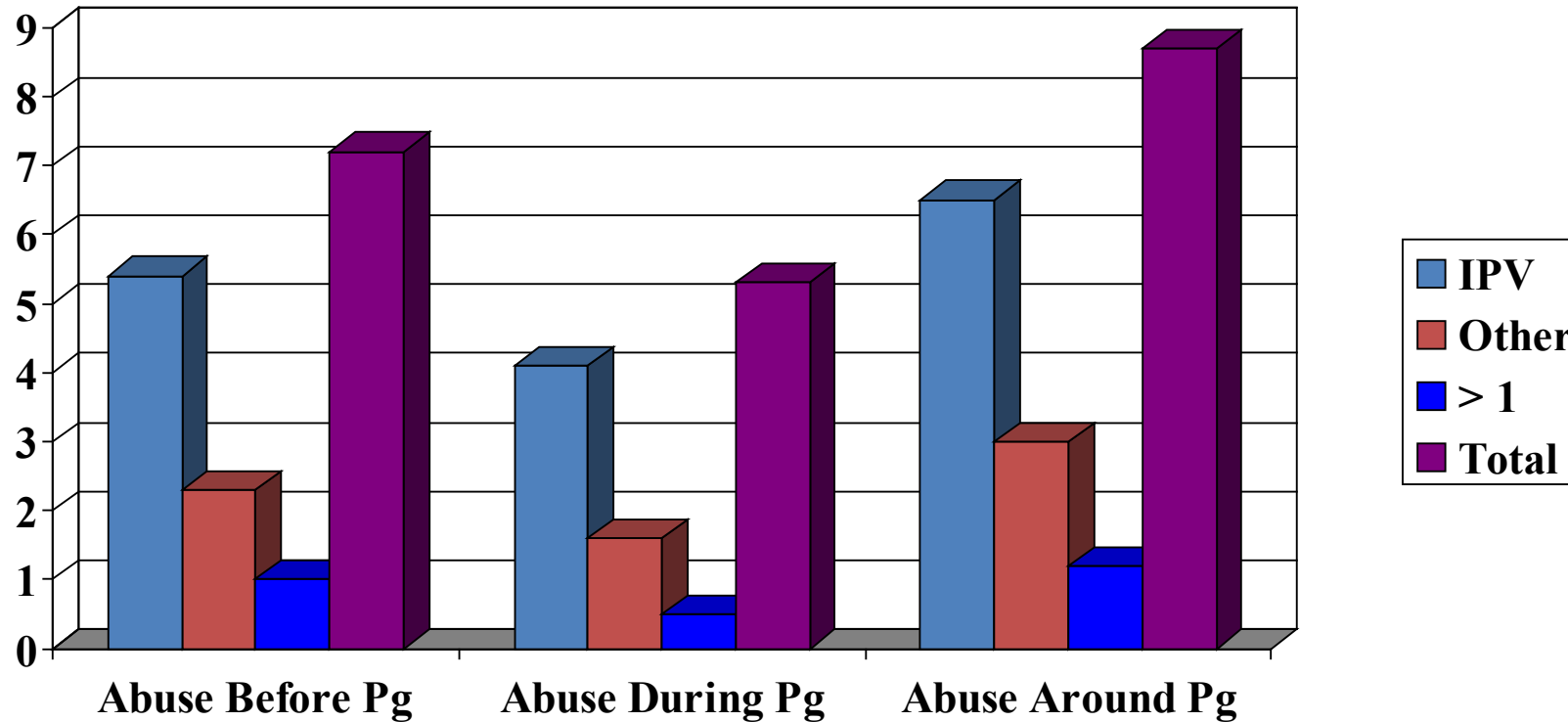
Abuse During Pregnancy

- 8-22% of pregnant women (vs. 7% pre-eclampsia or hypertension during pregnancy)
- Most significant risk factor - abuse before pg.
- Pregnancy - protective period or risk period (1st pregnancy - jealousy); usually neither
- Ethnic group comparison - significantly lower in Hispanic couples (Mexican American) -14% vs. 16% in African American and Anglo (McFarlane & Parker '92)

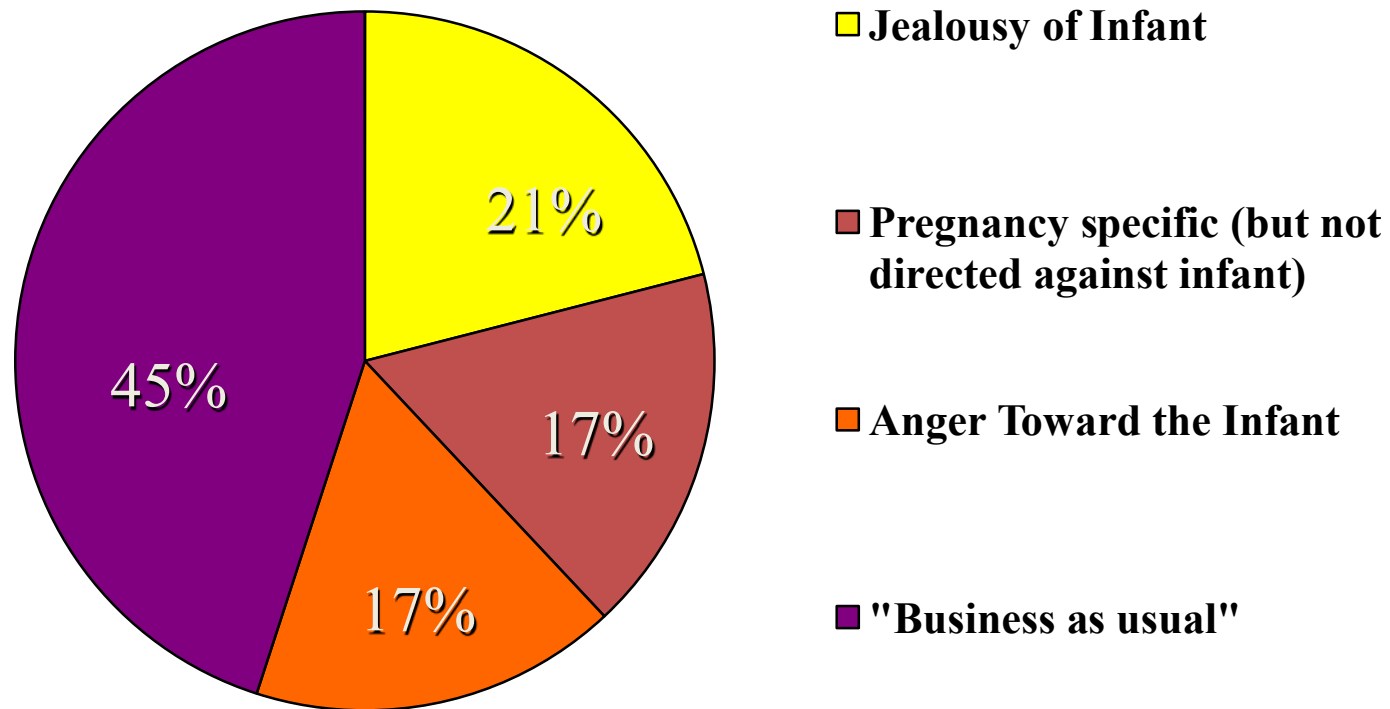
Patterns of Abuse During Pregnancy (Ballard et. al., '98)

- Used to think that pregnancy was a risk factor for abuse – now clear that more often a protective period but all patterns are possible –
- Pregnancy can be either a protective period – women beaten before and after – (30%) or a risk period – may start during pregnancy (24%) – especially first pregnancy - but most often neither (75%) (Martin '01; Saltzman '03)
- Physical abuse may lessen or stop but emotional abuse, controlling behaviors stay same or increase (Castro '03)
- Higher prevalence of abuse during pregnancy among adolescents than adult women (Parker, McFarlane '93) & post partum abuse higher than during pregnancy (Harrykisson et. al. '02)

Prevalence of Abuse Around Time of Pregnancy (Saltzman et. al. '03)



Themes of Women's Perceptions of Reasons for Abuse (Campbell, Oliver & Bullock '98)



N=27

Abuse During Pregnancy

- Maternal health correlates: depression, substance abuse, low social support spontaneous abortion, smoking, risk of homicide (Gielen et al '94; Campbell et al '92)
- Infant outcomes: LBW especially in MC women (Bullock & McFarlane '89) & through connections w/ smoking, low weight gain & substance abuse (Curry et al '99) ; child abuse
- Most severe abuse - nonbiological father

From Public Health Perspective – IP

Homicide = Maternal Mortality

- Maternal mortality – Death from all causes during pregnancy & year after delivery or pregnancy termination
- Homicide is leading cause of maternal mortality in US cities where measured (NYC, Chicago, DC) (Dannenberg, '95; Krulewitch et. al. 2001)
- Leading cause of maternal mortality in entire states of MD (Horon & Cheng, 2001) – 20% of deaths & MA (MMR '02)
- Has been neglected in maternal death reviews – (perpetrator data missing) & therefore programming in US but fatality reviews increasing

Multicity Femicide Study – Results related to pregnancy

- 25.8% of women killed reported abuse during pregnancy (vs. 8.4% of abused controls) – AOR = 3.8
- 13 women (4.2%) killed while pregnant – 11 of 13 abused in relationship before killed
- Stepchild in home increased risk AOR = 2.48
- Results specific to pregnancy published:
(McFarlane, Campbell et. al., 2002) *Obstetrics & Gynecology*, 100(1): 27-36

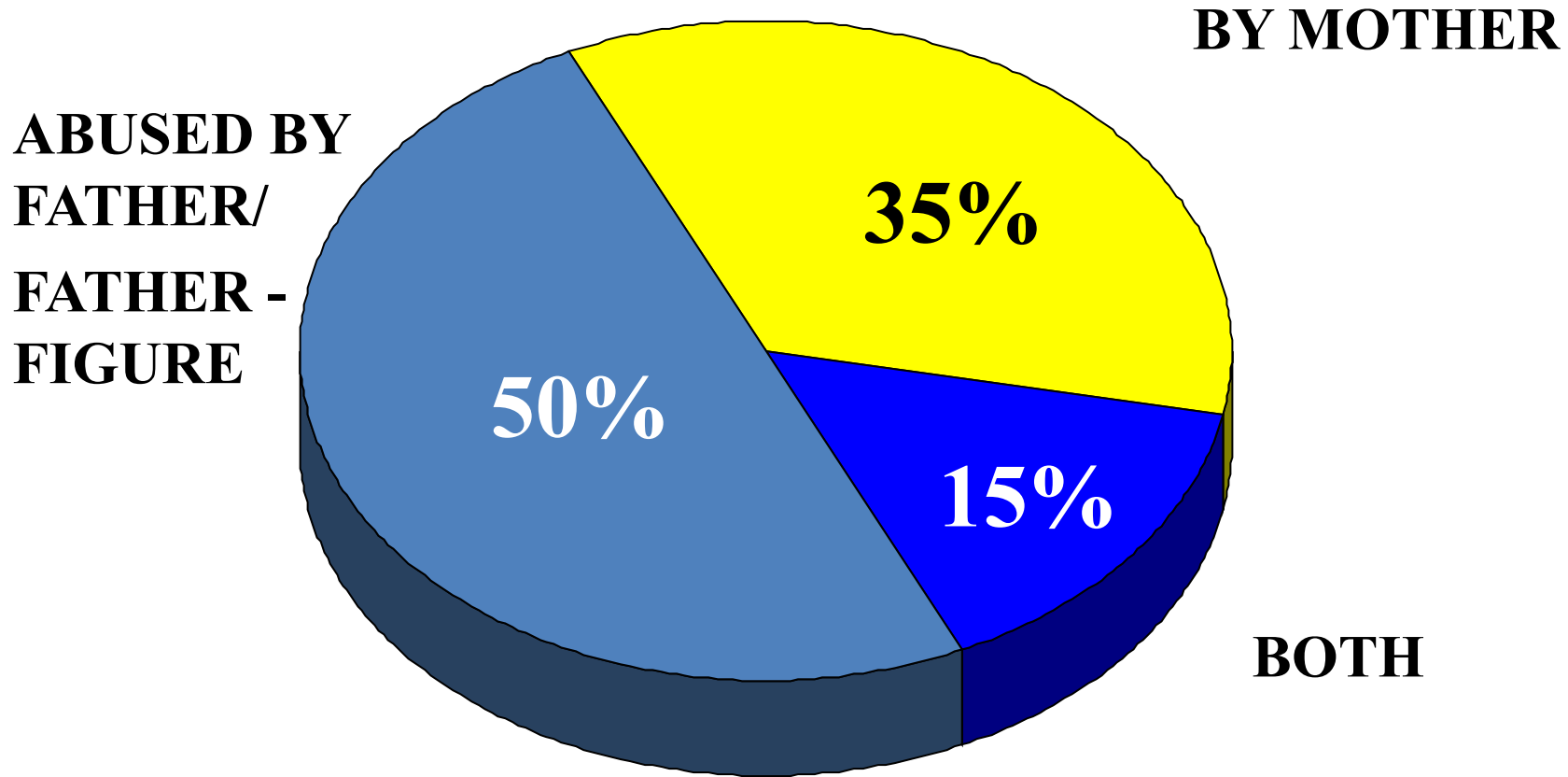
Clinical Implications of Abuse during Pregnancy

- Routine assessment at EACH prenatal care visit by regular provider (McFarlane & Parker '92)
- If abuse during pregnancy, alert for child abuse
- Understand particular tendency for hope for relationship during pregnancy
- Careful assessment at post partum

Child Abuse & Wife Abuse Overlap (Edleson '99)

- Hospital records of mothers of abused children 45 - 59% - evidence of wife abuse (Stark, Flitcraft '88; McKibben, DeVos, Newberger '89)
- State (OR & MA) DSS records 26 - 48% of mothers of abused children - wife abuse (Child Welfare Partnership '96; Hangen '94)
- Pop. based survey - 23% of men violent toward women - abused child; serious wife abuse - 77% child abuse (Straus & Gelles '90)
- Survey of college students - 52% (F) - 43% (M) of child witnesses - also abused (Silvern et. al. '95)
- Women in shelter - 20-46% children abused

CHILDREN OF BATTERED WOMEN
REPORTED FOR CHILD ABUSE X6



MEDICAL RECORD REVIEW (STARK & FLITCRAFT, 1988)

EFFECTS OF DV ON CHILDREN

- Anxiety reactions & post-traumatic stress Sx - e.g. irritability, agitation, trouble concentrating, exaggerated startle response, intrusive, unwanted memories, compulsive traumatic play (Graham-Bermann & Levendosky '02)
- More physical health problems than general pop. – asthma, eating disorders (Kerouac,et.al.'86; Wilkins '02)
- Worries about mother- actual (e.g. battering) & potential (e.g. smoking, pregnancy) health hazards (Humphreys '91;'93)

EFFECTS OF DV ON CHILDREN

- School problems, e.g., declining grades, behavior problems, truancy, suspensions, expulsion (Wolfe, et. al., 1986; Widon, Williamson & Wilson, 1991)
- Higher externalizing behaviors-e.g. aggressiveness, hyperactivity, conduct px, anger management px, bullying (Hughes '88; '89; Jouriles '89, Holden & Ritchie '91; Kolbo '96)
- Later, higher levels of violent behavior & arrests in children abused or neglected (Maxfield & Widom, '96)

EFFECTS OF DV ON CHILDREN

- Higher internalizing behaviors, e.g., depression, anxiety, social withdrawal (Hughes, 1988; Holden & Ritchie, 1991; Graham-Berman & Levendosky '01)
- Low social competence. Fewer interests & social activities (Wolfe, et. al., 1986)
- Low self-esteem, low self-efficacy (Hughes, 1988; Holden & Ritchie, 1991)
- BUT most children recover when violence ends IF a stable, caring adult - resilience research

Physical Health Effects of Lifetime Trauma

- ACE study – Felitti '98; '02; '03
- Men & women victims of child abuse & neglect – longterm health effects – premature death from cardiovascular disease as well as smoking, drug abuse, alcoholism
- Increasing evidence of weight disorders – increased body weight
- Combinations of risk factors – complex physiological & neuropsychological interactions

MENTAL HEALTH EFFECTS - Golding '99

- **Depression 10 - 43 pop; 32 - 70% clinical (9.3% non abused)**
- **Suicidality 14 - 40% (4.9% non abused)**
- **Post Traumatic Stress Disorder 2 - 12% pop; 31 - 84% clinical (weighted X prevalence 64% - 5% non abused)**
- **Alcohol Abuse 4 - 16% pop; 23 - 44% clinical**
- **Drug Abuse 5 - 16% pop; 23 - 44% clinical (2% non abused)**
- **Eating Disorders - bulimia (McCauley et.al.1995)**

Post Traumatic Stress Disorder in Battered Women

- Re-experiencing the trauma
 - Trouble sleeping
 - “Affective” flashbacks
 - Dissociation rare unless learned in childhood
- Avoidance of stimuli associated with event
 - “Denial”
 - Encouraged by “conventional wisdom” but counter indicated

Post Traumatic Stress Disorder in Battered Women

- Hyperarousal
 - Startle response
 - Hypervigilance
 - Stress related physical symptoms
 - Substance abuse as self medication?
- Normal Human Response to Trauma BUT increasing evidence of neurochemical brain changes - hypothalamus & serotonin

Co-Morbidity of PTSD & Depression in Battered Women

- Far more comorbidity in battered women than in rape victims or Vietnam Vets
- Predictors: childhood victimization, severity of physical abuse
- Beginning evidence that a lifetime trauma response

Issues with Depression in Battered Women

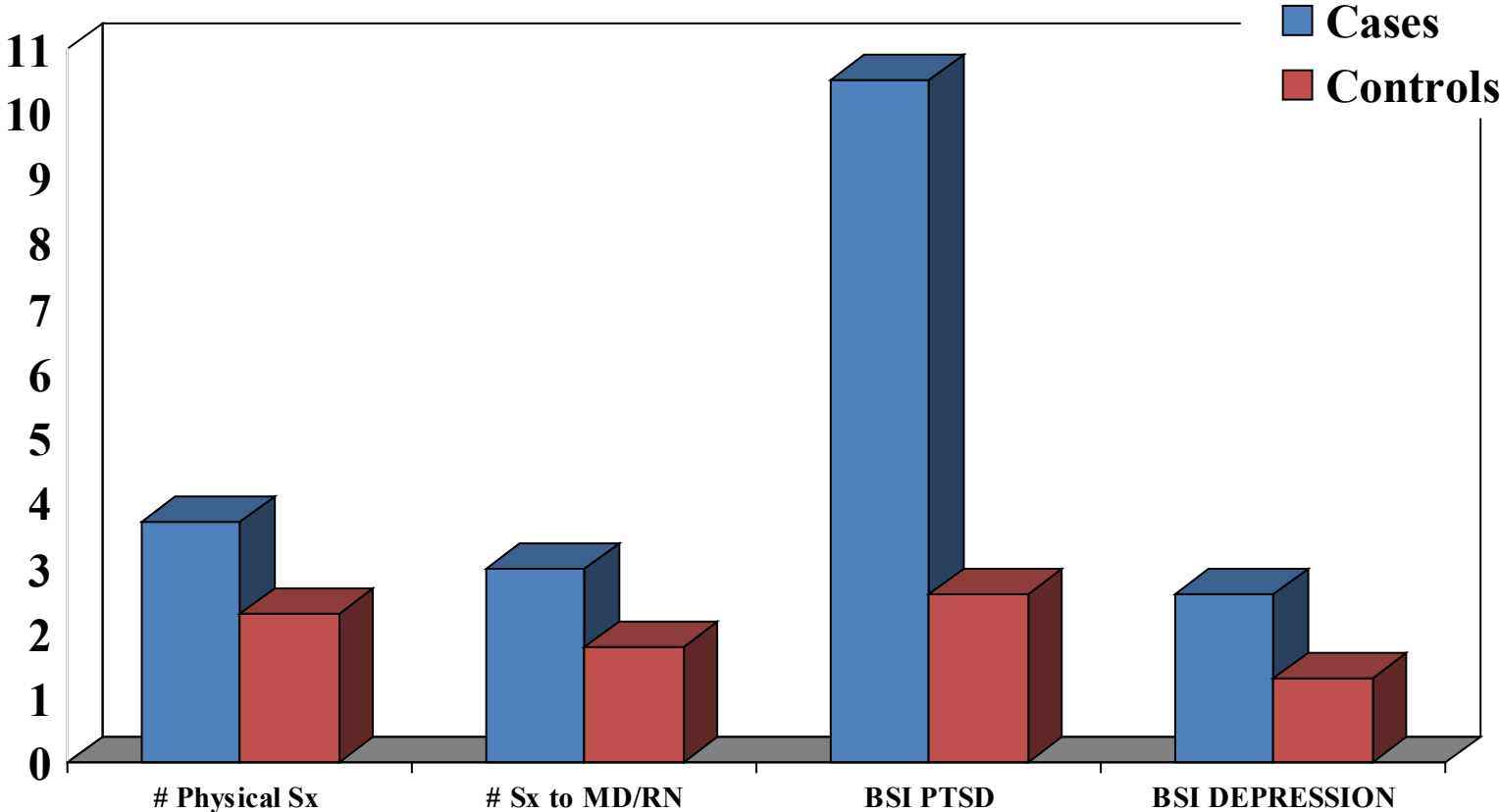
- Diagnostic issues
- Labeling issues
- Child custody issues
- Medication issues
- Other treatment issues
- Interaction of biochemical & environmental
- For most women, depression lifts as abuse lessens (Sullivan et. al. '98; Campbell & Soeken '99)

Health Care Costs of Intimate Partner Violence (Wisner et.al.JFP '99)

- 126 victims compared to 1007 randomly selected HMO female enrollees (Minneapolis) 18-64 yo.
- \$1775 more spent per year
- Significant differences: Increased hospitalizations, general clinic use, mental health visits and “out of plan” referrals
- ED visits *not* higher
- Mental health care costs 800% higher

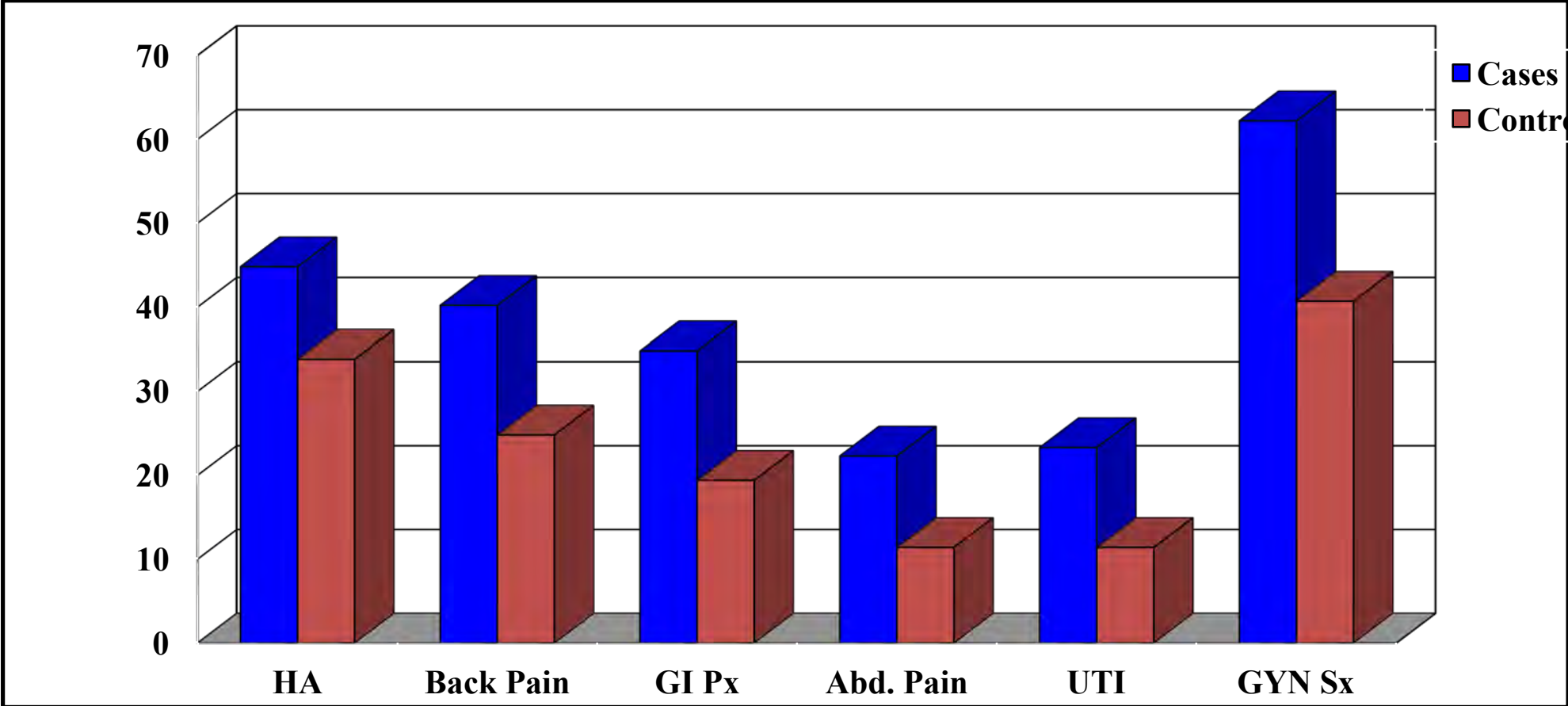
Health Problems & Symptoms Experienced in Past Year

MLR analysis controlling for case/control differences - race, marital status, ed & income



P < .001
Cases N=202
Controls N=240

Selected Health Problems at Least One Time to MD: Significant Difference btw. Cases & Controls



Differences between African American & Anglo HMO Enrollees (Schollenberger et.al.'03)

- More African American women overall to ED & past year abused African American women made most visits
- $P < .05$ difference in hypertension between those with past year abuse & those never abused - African American women only
- Significant association between abuse (ever) and fibroids & colds & flu for African American women only
- Less difference btw. abused & not in total clinic visits for African American women than for anglo women
- No significant difference in loss of appetite for African American women vs. significant difference for anglo

Policy Implications (Gielen, Campbell et. al. '00)

- Of the 118 ever abused women, only 18.6% had talked to a health care provider about the abuse
- Of those, 61% said it was either somewhat or entirely helpful; 17.4% not helpful
- Majority abused (60.5%) & not abused (80.6%) not insulted/offended if asked about abuse (*p <.05)
- Majority of both groups (83.3%) - said easier for battered women to get help if health care providers routinely asked about abuse

Routine Screening & Mandatory Reporting Conclusions

(from 3 samples - ED, HMO, & urban population based)

- Majority of women - abused & not - support Routine Screening & MR- generally think it would make it easier for women to get help & like someone else calling police
- But significantly fewer abused women support MR (Hispanic battered women least in favor) & significantly more endorse options for choice
- Slight majority of battered women say MR would decrease disclosure
- Sizeable minority of battered women (44 - 50%) think MR may increase risk

PROTOCOLS (Required by JCAHO)

RECOMMENDED ELEMENTS:

- Procedures for separating
- Ask all females
- Complete physical exam
- Legal responsibilities
- Referral sources

FRAMEWORK FOR HEALTH CARE SYSTEM

R - Routine Screening/Assessment

A - Ask Direct Questions/

D - Document Findings

A - Assess Patient Safety

R - Review Options

WHY ROUTINE ASSESSMENT? ALL WOMEN/ALL VISITS

- Prevalence across lifespan - prevalence higher than hypertension in young & midlife women
- Past yr. prevalence always higher than injury from abuse
- Few consistent pre-existing characteristics - providers will not be able to tell unless ask
- Abuse status change over time
- May be etiology of or aggravate presenting problem
- May compromise treatment of existing problem
- Until clinical trial evidence of benefits more than cost/risk – proceed under Routine Assessment guidelines – like alcohol px

“The Woman Who Walked into Doors”

Roddy Doyle ‘96

“I fell down the stairs again, I told her. - Sorry. No questions asked. What about the burn on my hand? The missing hair? The teeth? I waited to be asked. Ask me. Ask me. Ask me. I’d tell her. I’d tell them everything. Look at the burn. Ask me about it. Ask.”

The Woman Who Walked into Doors

Roddy Doyle '96

“I’d get worked up waiting. I believe it was just a matter of luck. Maybe this time. A nurse would look at me and know. A doctor would look past his nose. He’d ask the questions. He’d ask the right question and I’d answer it and it would be over. Charlo was always with me. He was always there. Behind the curtain was the only time I was alone. His shadow on the curtain. A few minutes. One question. One question. I’d answer; I’d tell them everything if they asked..... Ask me.”

PURPOSES OF ROUTINE ASSESSMENT/INQUIRY

- OPPORTUNITY CREATION - FOR DISCLOSURE, SEEKING HELP EARLY, A PLACE OF SANCTUARY FOR THOSE NOT READY FOR SHELTER, COUNSELING, CRIMINAL JUSTICE
- PRIMARY PREVENTION - EDUCATION ABOUT ISSUE
- RATHER THAN DETECTION

Routine Assessment Protocol: All women aged 14 & over ('04 FVPEF.ORG)

- Primary Care - Every: 1st visit for new cc, new pt. encounter, new intimate relationship & periodics
- ED & urgent care - All visits
- OB/GYN - Each prenatal & pp visit; new intimate relationship; routine gyn visit, family planning, STD clinic, abortion clinic
- MH - Every initial assessment; each new intimate relationship & annually if ongoing or periodic tx.
- Inpatient - as part of admission & discharge

New Horizons - Opportunities for Secondary Prevention

- Employee Assistance Programs & Occupational Health - majority of hospital employees are women
- Discharge Planning
- Managed Care
- Substance Abuse Treatment
- Mental Health
- School Health, Healthy Start, Community Based Programs

HOME VISITATION SCREENING

- CHALLENGE: PRIVACY FOR ASSESSMENT - ABUSE ASSESSMENT SCREEN
- OUTSIDE, BABY'S ROOM, KITCHEN, TAKING A WALK - ALL PLACES FOR NATURAL ASSESSMENT
- "We have to do some private stuff now"
- RECOMMENDED ASSESSMENT: FIRST VISIT - FOR SERIOUS VIOLENCE & SAY WILL ASSESS AGAIN
- THIRD VISIT - TRUST BEGINNING & ANY OTHER TIME SEE INDICATIONS - e.g. depression, STD's
- POST PARTUM - 1WK, 2 WKS, 6 WKS. & 3 MOS.
- BABY INDICATORS: sleeping px, colic, nonbiological father, breastfeeding barriers, concerns about "spoiling"

Home Visitation Intervention

- Use brochure driven intervention
- Take brochure with you - use for recording information, safety plan, follow-up
- Leave “Women’s Health Resource” list for referral numbers
- Talk to her about including older children in discussions if she agrees - also extended family
- Discuss military vs. civilian services - advantages & disadvantages

ABUSE ASSESSMENT SCREEN

1. **Have you ever been emotionally or physically abused by your partner or someone important to you?**
2. **Within the last year, have you been hit, slapped, kicked, pushed or shoved, or otherwise physically hurt by your partner or ex-partner?**

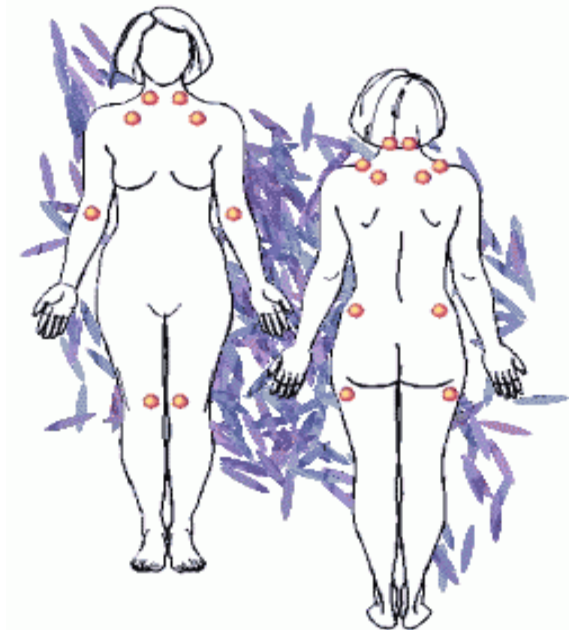
If YES, by whom _____

Number of times _____

3. **Does your partner ever force you into sex?**
4. **Are you afraid of your partner or ex-partner?**

Heltin & McFarlane, 1986

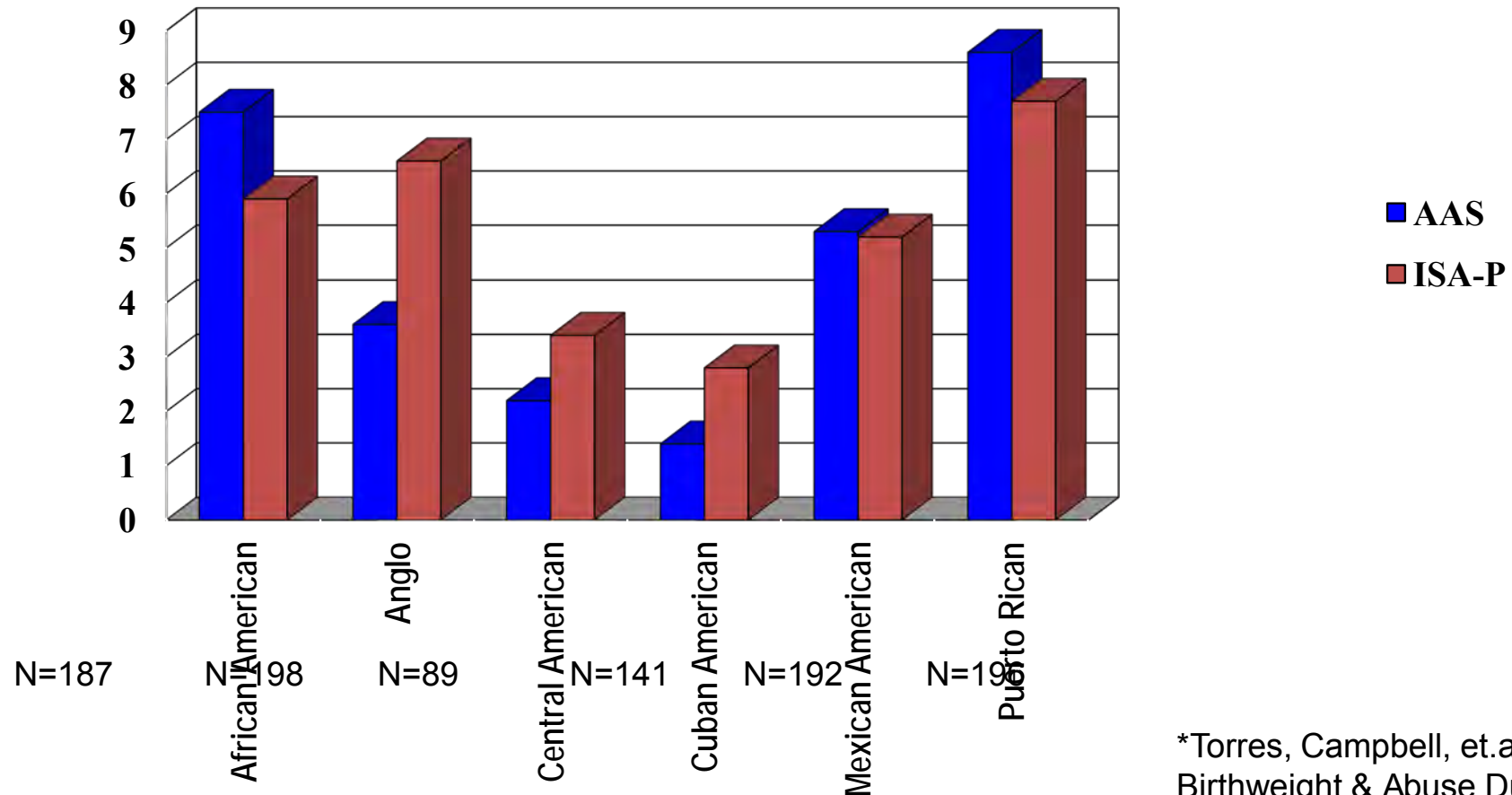
Mark the area of any injury on body map.



Pediatric Settings – See FVPF.org or endabuse.org also PCADV

- Within general assessment for safety at home broadly – guns etc.
- Ask about adults being abusive to each other or about mother's relationship with intimate partner or ex-intimate partner
- Or use AAS – pilots being conducted as to best approach
- Mothers in pediatric settings find routine inquiry acceptable
- Asking in front of children – may need to distract children or obtain privacy – depending on age
- Issues with confidentiality – not putting in child's record – child abuse reporting issues

Abuse During Pregnancy By Ethnic Group And Assessment (N=1000)



*Torres, Campbell, et.al. '99
Birthweight & Abuse During
Pregnancy (NINR)

DOCUMENTATION

Charting Should Include:

- Date and time care provided
- Patient's own words-"My husband, John Jones, struck me in my face on X date at X time"
- Patient demeanor
- Complete medical & social history and physical exam
- Patient's explanation response to direct questioning about abuse

DOCUMENTATION

Charting Should Include:

- Results of pertinent lab and diagnostic procedures
- Injury map and/or photographs
- Discussion of safety assessment and referral plan
- Any police involvement (including badge number)
- Lethality assessment

Note: this documentation should be a collaborative effort between all appropriate health care team members per policy,/protocol

EXCITED UTTERANCE

- Exception to hearsay rule
- Made for purpose of medical diagnosis or treatment or and describing medical history
- Statements made to MD, SW, or RN
- Upheld 1995 in STATE V. SIMS, Washington (Domestic Violence Case)
- Recent challenge from '03 Supreme Court Case

PHOTOGRAPHS

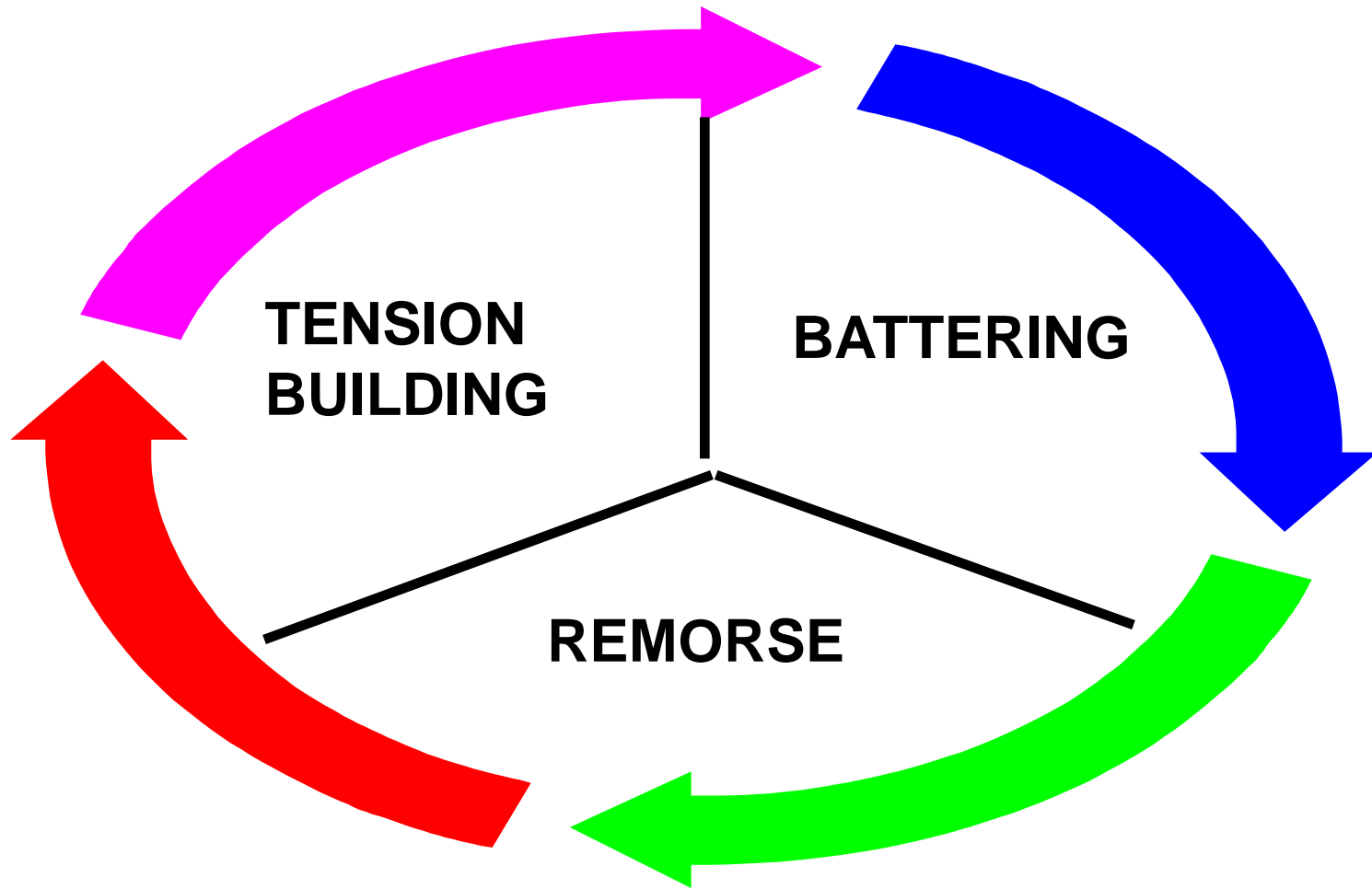
Camera accessible 24 hours a day?

- Patient permission
- Digital vs. Poleroid – some controversy regarding possible alterations
- Photograph before treatment
- Photographs from all angles - so that patient identifiable

TEN MINUTE INTERVENTION

- BROCHURE DRIVEN - COMMUNITY INDIVIDUALIZED
- SET ABUSE IN CONTEXT - CYCLE OF ABUSE OR POWER & CONTROL WHEEL
- LETHALITY ASSESSMENT
- SAFETY BEHAVIORS - MENU - SHELTER, OTHER SERVICES ORDER OF PROTECTION, PUTTING MONEY ASIDE, HAVING CHILDREN GO TO NEIGHBORS

Cycle of Abuse



**NATIONAL DOMESTIC VIOLENCE
HOTLINE
1 800 799-SAFE (7233)**

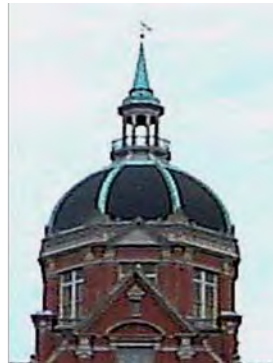
DOMESTIC VIOLENCE PROGRAMS

Range of services

- Shelter
- Batterer's Counseling
- Non-Residential Counseling
- Children's Counseling
- Victim Advocacy
- Court Companion Services
- Attorney Services

SHELTER EFFECTIVENESS

- Support Group Effectiveness (Tutty, Bidgood, & Rolnet, 1993)
- Shelter Stay Effective If Economic Follow-up Support (Davidson, et. al. 1991)
- Slight Majority of Battered Women Leave With or Without Shelter Services (Campbell, et. al., 1994; Okum, 1986)
- But Leave Several Times Before Leave For Good
- And Highly At Risk When Leave



IMMIGRANT BATTERED WOMEN

- LANGUAGE ISSUES

 - Means of control

 - Family member as translator

 - Learning English

- IMMIGRATION STATUS -DO NOT CALL INS!! -GET IMMIGRATION LAW SPECIALISTS

 - Waiver of joint filing

 - VAWA-Self petition

- POLICE-PERCEPTIONS OF IMMIGRANTS

- FVPF – FVPF.ORG;NOW LDEF (202) 326-0040

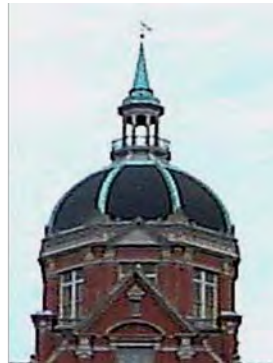
Safety Strategies

- Engage her best parenting skills & desires - listen to the kids (Henderson & Erikson '92; Sullivan '99)
- The gun(s) - safety pamphlets; search warrants
- If she plans to leave, cannot do face to face
- If she leaves to get him into intervention - stay gone until he completes
- Engage employers, relatives, neighbors - help her break out of the isolation
- Put \$\$ aside - employment opportunities
- Ensure follow-up

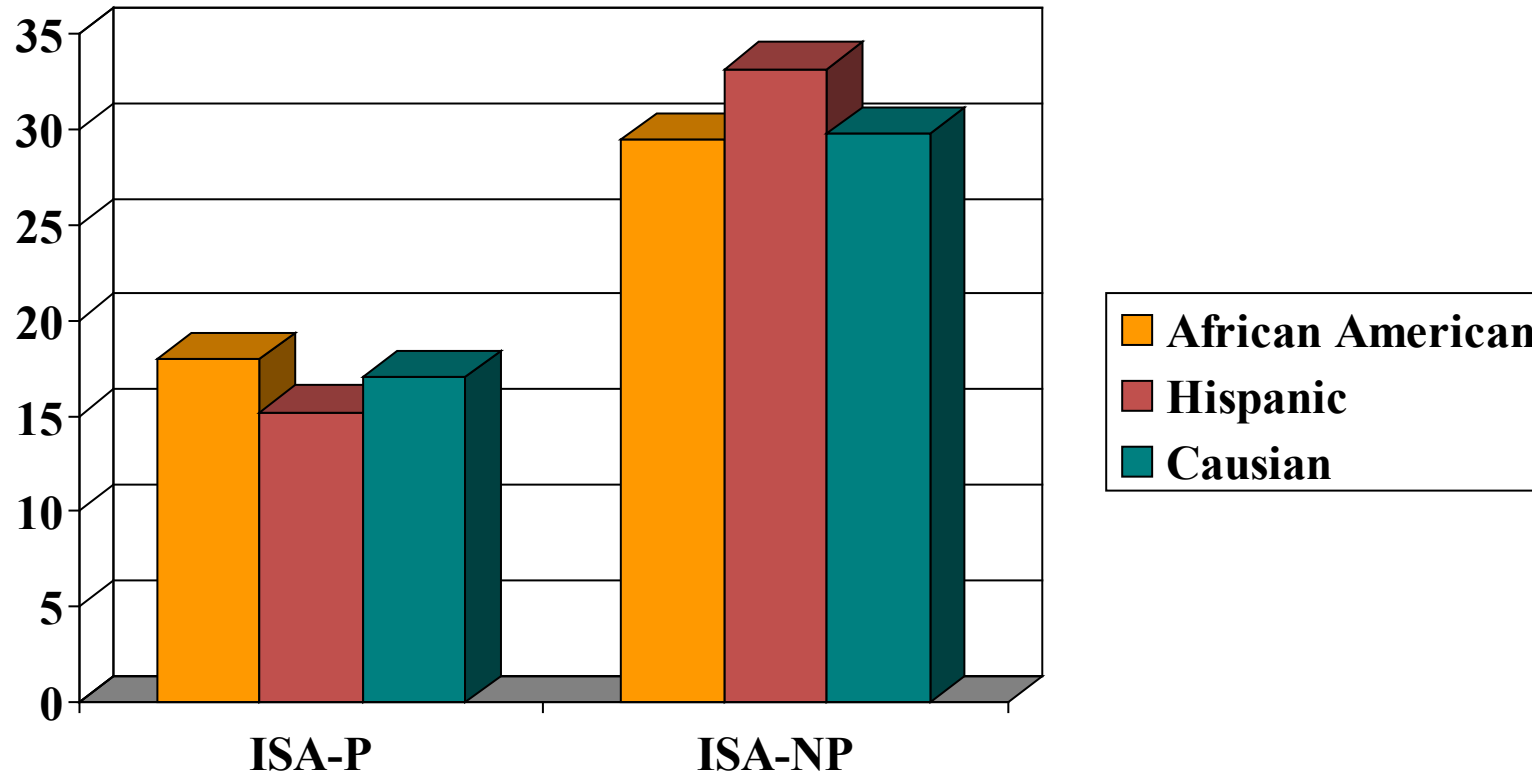
Tested Ten Minute Nursing Intervention (CDC funded)

- N = 132 poor, pregnant, urban and rural
- 36% African American; 34% Hispanic; 30% Anglo
- Longitudinal (10% attrition) - 3 intervention visits during pg.; 3 follow-up - 0, 6, 12 mos.
- Significantly more safety behaviors used by intervention group

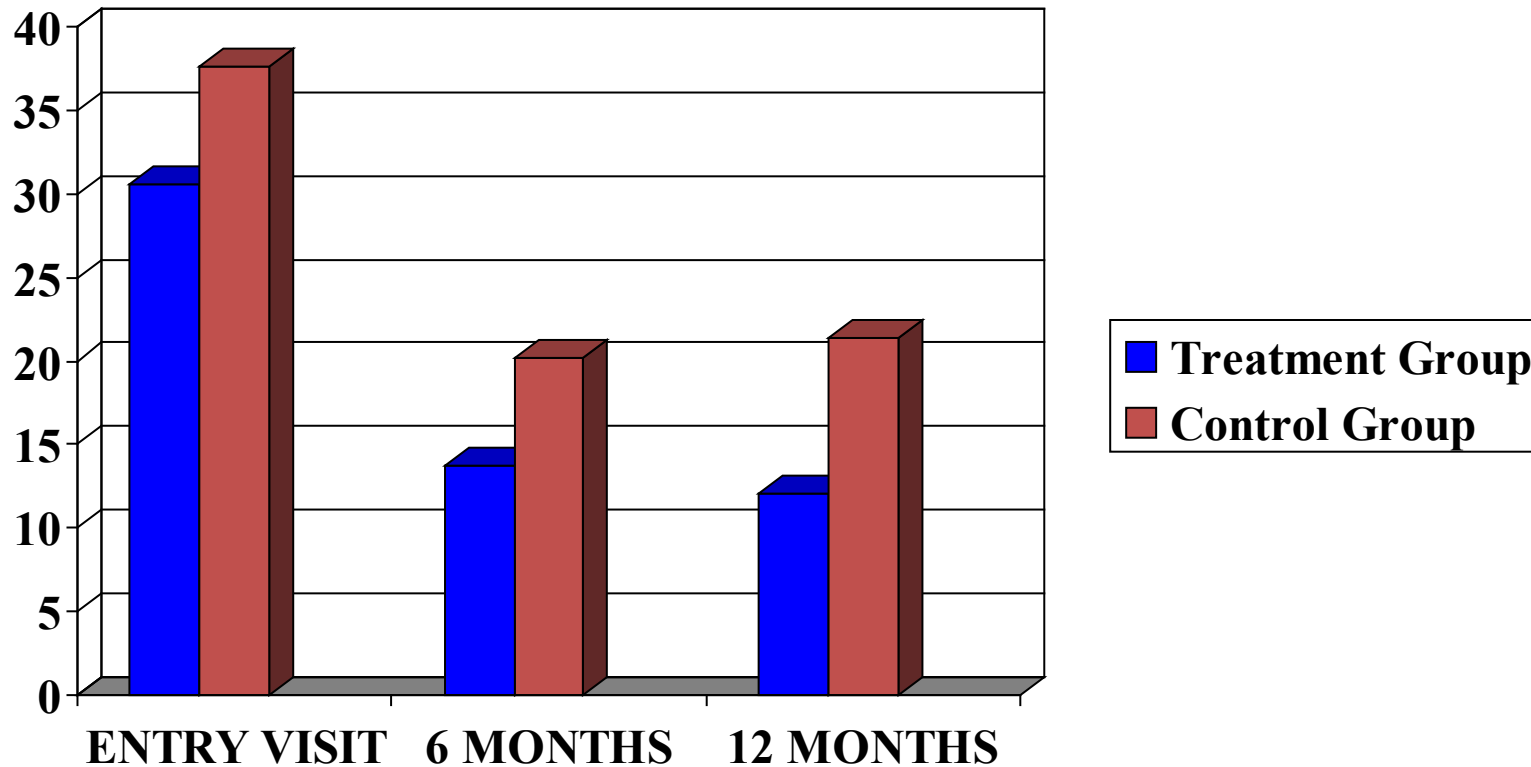
(McFarlane, Parker, Soeken, Silva & Reel, JOGNN, 1998)



ADJUSTED MEAN INDEX OF SPOUSE ABUSE (ISA) SCORES BY ETHNIC GROUP

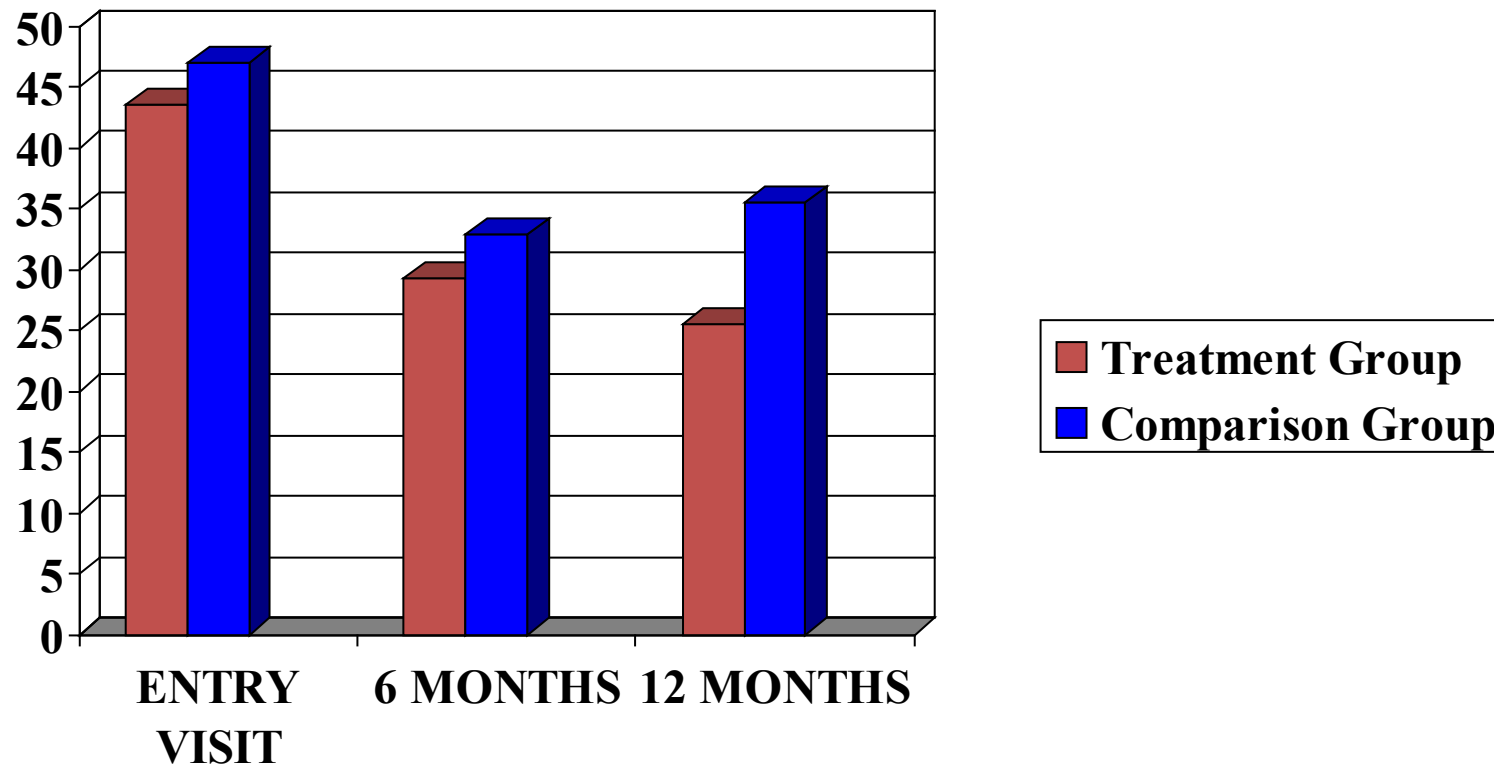


ADJUSTED MEAN INDEX OF PHYSICAL SPOUSE ABUSE (ISA-P) SCORES BY TREATMENT GROUP



MANCOVA $F=5.04$ $P=.07$, Parker, McFarlane, Soeken, Silva, & Reel, (1999)

ADJUSTED MEAN INDEX OF NON-PHYSICAL SPOUSE ABUSE (ISA-NP) SCORES BY TREATMENT GROUP



COMMUNITY TEAM PROCESS

