Module 2 Health care: Domestic violence and appropriate response in health care settings

Timeframe: app. 45-60 minutes

Content:

Topic 1: Intervention steps and screening tools

Topic 2: Identifying victims/Red flags (Input and handout)

Topic 3: Interviewing the victim and further appropriate responses

Topic 4a: Risk assessment and safety planning

Topic 4b: Referral to support system

General objectives:

The participants are aware

- how victims can be identified and interviewed
- which intervention steps should be taken
- which risk assessment and safety planning are necessary
- how to refer to supporting systems
Background information

Topic 1: Intervention steps and routine enquiry

Health professionals are in a good position to help and support women who experience intimate partner violence. For example, routine health checkups offer an excellent opportunity to recognise victims of abuse. Moreover, confidentiality required from health professionals is a basis for women to talk about their experience of violence. However, it is important that health professionals initiate a conversation about violence since women usually find it very hard to talk about their experience (Bacchus et al. 2002). (Perttu & Kaselitz 2006.)

Routine enquiry, which is also referred to as routine screening or universal screening, means screening conducted routinely for all individuals or specified categories of individuals in a specified situation. That means asking all patients about domestic violence regardless of what medical or health problems they are presenting with. Unlike routine screening, indicator based screening, or selective screening, refers to asking patients with certain conditions that may raise suspicions such as women who attend and talk about depression, women who attend with sexually transmitted infection or unexplained injuries etc. (Preventing Domestic Violence: Clinical Guidelines on Routine Screening19991.)

Routine enquiries for intimate partner violence should be introduced. If concerns arise in any situation it should always be possible to address them. However, health professionals are just one group in a system of support to help victims of violence. The special role of the health professional is in identifying victims of violence and in initiating a process of ending violence. It is important that health professionals co-operate with other help providers and authorities. Clinics and doctor’s practices should also have information posters, leaflets and information cards available. (Perttu & Kaselitz 2006.) Professionals are able to intervene to help patients understand their options, live more safely within the relationship or safely leave the relationship (Preventing Domestic Violence: Clinical Guidelines on Routine Screening1999.)

However, most women do not disclose being victims of intimate partner violence to health professionals even though they most often seek help from these professionals. If the majority of health professionals do not ask about intimate partner violence most cases remain unnoticed (Bacchus et al. 2004 a). Screening questionnaires are sometimes used and those are based on the experience of health professionals. Those are helpful in asking about violence in intimate relationships and about violence against children. (Read more about screening tools in maternity and child health care and in medical examination Perttu & Kaselitz 2006, 30-32: Abuse Assessment Screen; McFarlane & Parker 1994, also see the handout topic.1:APPENDIX.)

All females aged 14 years and older should be screened routinely for domestic violence, but screening should be conducted by a health care provider who has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and
cultural competency. Professionals should be trained how to ask about violence and to intervene with identified victims of abuse. Professionals should know how to respond when violence is identified. (Preventing Domestic Violence: Clinical Guidelines on Routine Screening 1999.)

Screening should be part of a face-to-face health care encounter, be direct, non-judgemental, take place in private (no friends or relatives of the patients should be present) and be confidential. There should always be professional interpreters when needed and screening should be included as part of a written health questionnaire. (Preventing Domestic Violence: Clinical Guidelines on Routine Screening 1999.)

Screening should occur as part of routine health history and standard health assessment, during an initial visit for a new chief complaint or every new patient encounter. It should also occur with regard to every new intimate relationship and during every periodic comprehensive health visit. Screening should take place in settings like primary care, urgent care, Ob/Gyn and Family Planning, Mental health and Inpatient. (Preventing Domestic Violence: Clinical Guidelines on Routine Screening 1999.)

When violence/abuse is suspected, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician’s recognition and validation of her situation is important. Recognition, acknowledgment, and concern confirm the seriousness of the problem. (American Medical Association 1992.)

The health professionals’ important task is to assure that the client’s experience is validated and to justify her feelings about the violence. The professional’s role is to help the client acknowledge that there is violence in her life and to show that s/he believes the client’s story and what has happened to her. This requires a measure of active listening and support; passive listening alone, with no comments can make her doubt what has happened and can make her think that she is wrong. In addition to physical and sexual violence it is important to pay attention to psychological violence and to the partner’s use of power and control. The health professional’s role is to support the women through the process of realising what is happening to them. (Perttu and Kaselitz 2006.)

Below is a 10 points memory list of intervention steps to keep in mind when meeting the patient and asking about violence. These ten points are valid for both routine enquiry and indicator-based screening.
1. **Start by developing trust**  
   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. Use professional interpreters when needed (not the patient’s friend or family member).

2. **Take the initiative to ask about the violence**  
   Do not wait for her to bring it up. Ask and listen to her experiences. It can happen that she is not willing to tell about the violence or may fear you would doubt it.

3. **Ensure privacy**  
   The victim’s and the child’s safety are paramount. Always ask about the violence when you are alone with the woman, do not ask when she is accompanied by her partner, sister, daughters, friends etc. Try to make sure that it is safe for the patient to return home.

4. **Identify risk factors of intimate partner violence**  
   For example, do not overlook disabled or old women. Disabled old women are at a greater risk of becoming a victim of violence.

5. **Talk about legal protection options for victim and child(ren)**  
   Tell the victim that violence is always a crime.

6. **Discuss beliefs related to violence with the victim**  
   Give information on the facts: prevalence of violence against women; she is not guilty of, nor responsible for the 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.

7. **Tell the victim about the impact of violence**  
   Estimate victim’s needs for an immediate crisis or intervention visit at a psychologist or at a psychiatrist. Tell her about the impact of violence on victims (for example about burnout, impacts on physical health). Motivate the client to seek psychological help.

8. **Always document the interviewing process and tell the victim what you write down**  
   Good documentation can be the most important evidence in case of conflict. Doctor’s statements, records from health care and other professionals, messages on answering machines, SMS, e-mails, letters, the victims’ diary etc. can be used as an evidence.

9. **Tell the victim about further appropriate services**  
   Tell her about services available which can offer support and assistance. Be aware of services in your region. Give the woman information on local and national support agencies and help lines. You can also make an appointment for her at one of the services. For example: guide and help the woman to go to the doctor’s reception even if you only suspect physical and/or sexual violence. Tell her that a doctor’s visit and statement is relevant for her legal protection.
10. Don’t ever leave the patient alone.
Meet her again, if there is no available service at that moment.

- An abused woman needs specific support in order to cope with the consequences of violence. If the assaulter seeks/has sought help for himself, it is recommended that the victim seek help somewhere else. It is important that the children get help as well. Children have a right to talk about their experiences without the presence of their parents.

(Perttu & Kaselitz 2006; Ota väkivalta puheeksi (bring up violence) - Etelä-Suomen lääninhallitus, Sosiaali- ja terveysministeriö 2007.)

The following intervention standards are also meant to enhance the professional’s ability to meet the patient’s needs. The standards call for a confidential setting.

1. Never advise a woman to leave her partner.
2. Let the woman know that you believe her
3. Never be tempted to act as a go-between.
4. Don’t try to make decisions for her.
5. Support the woman in whatever decision she makes
6. Give the woman information
7. Encourage her to see that there is life after abuse


> S.I.G.N.A.L. Intervention Protocol (see also module 4)

The guidelines for the S.I.G.N.A.L program that articulate its intervention model and the range of measures that can be taken against domestic violence were developed by RADAR, an intervention project in the United States. Many intervention models have been field tested in Anglo-American countries. As with other intervention models, the S.I.G.N.A.L program is based on the following intervention steps:

- Actively questioning patients about any experiences of violence
- Documenting injuries and health problems for use in legal proceedings
- Assessing risk and planning for safety
- Disseminating information regarding advice, counselling and shelter facilities

These intervention steps come together to form the ‘S.I.G.N.A.L’ guidelines. These have been developed as guidance for establishing relevant contact with victims of sexual and domestic violence. Each letter of the acronym stands for a guideline recommendation.
S Speak to the patient and signal your readiness to help.
Women open up if they sense that someone is really listening to them and is willing to take their problems seriously.

I Interview the patient, using simple, practical questions.
Listen without being judgemental.
Listen without being judgemental. Women are often afraid of not being taken seriously, and they tend to feel ashamed. They may have difficulty speaking to someone else about the violence they have suffered.

G Make a careful examination of new and old injuries.
Injuries at different stages of healing may be an indication of domestic violence.

N Note and document all medical findings and information in such a way that they could be used as evidence in court.

A Establish the patient's safety requirements.
Every intervention must aim at providing the victim with protection and ending violence.

L Offer the patient guidelines for personal behaviour together with emergency phone numbers.
Patients will make use of this when they feel that the time is right.


Topic 2: Identifying victims/ Red flags/ possible signs of domestic abuse in women

Consequences of intimate partner violence/ Women victims

Consequences of intimate partner violence can be emotional/ cognitive, behavioural or somatic symptoms/illnesses. For a professional it is very important to recognise that the following symptoms could be consequences of violence. (See Perttu & Kaselitz 2006.)

Emotional/cognitive

- fearful behaviour/hypersensitivity/startle reactions
- lack of interest/depression
- excessive dependence or isolation
- hostility, irritability or outbursts of anger
- rapid changes of mood/ambivalence
- feelings of loneliness/being different/stigma
• feeling permanently damaged (feeling as though one had no future anymore)
• anxiety/feeling trapped
• loss of feelings/"frozen self"
• sleep disturbances: trouble falling asleep or staying asleep, insomnia, nightmares
• increased use of/dependence on drugs/alcohol
• suicidal tendencies (thoughts/attempts/committed suicides)

**Behavioural**
• 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 (e.g. books, TV)
• poor parenting responses, child abuse
• Frequent appointments for vague symptoms

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

(Perttu & Kaselitz 2006.)
Red flags of domestic abuse in women

There are also so called red flags of domestic violence, which are very important to recognise during the medical treatment.

- Injuries inconsistent with explanation of cause
- Woman tries to hide injuries or minimise their extent
- Partner always attends unnecessarily
- Woman is reluctant to speak in front of partner
- Suicide attempts – particularly with Asian women
- History of repeated miscarriages, terminations, still births or pre-term labour
- Repeat presentation with depression, anxiety, self-harm or psychosomatic symptoms
- Non-compliance with treatment
- Frequent missed appointments
- Multiple injuries at different stages of healing
- Patient appears frightened, overly anxious or depressed
- Woman is submissive or afraid to speak in front of her partner
- Partner is aggressive or dominant, talks for a woman or refuses to leave the room
- Poor or non-attendance at antenatal clinics
- Injuries to the breasts or abdomen
- Recurring sexually transmitted infections or urinary tract infections
- Early self discharge from hospital

None of the above signs automatically indicates domestic abuse. But they should raise suspicion and prompt you to make every attempt to see the woman alone and in private to ask her if she is being abused. Even if she chooses not to disclose at this time, she will know you are aware of the issues, and she might choose to approach you at a later time.


Recognising the perpetrator

It is always important to strive for a comprehensive approach to health care provision for the sake of the victim’s safety. That also means that it is important to try to identify the perpetrator while meeting the victim, or to identify the perpetrator when possible. For example, professionals can meet the perpetrator in the emergency unit while they are helping the victim of violence, his wife. At that time it is important to try to get the perpetrator connected with services to address his violent behaviour.

In Finland there was a group discussion at a multiprofessional training day (22.4.2008) about how to identify the perpetrator. There were 33 participants from different professions such as nurses, midwives, social workers, deacons, and mediators.
The outcomes of the group discussion were written on the flipchart. The participants produced many warning signs to help identify victims of violence, whereas it was more difficult to find warning signs suggesting a perpetrator. One important note was that there are no unequivocal signs and sometimes no signs at all. Therefore, the worker has to be sensitive and “sharp-sighted”.

There are also signals from men who are worried about their abusive behaviour. They may say the following things (Domestic abuse Training Manual for Health Practitioners):

- I've got a problem with drink
- I need anger management
- I'm not handling stress at work well
- My wife says I need to see you
- My wife and I are fighting a lot
- My wife and I need counselling
- My wife is not coping and taking it out on me
- The kids are out of control and she’s not firm enough
- I'm depressed/anxious/stressed/not sleeping/not coping/not myself
- I feel suicidal (or have threatened or attempted suicide)
- I'm worried about my rage at work, in the car, in the street, at the football match.

There are also additional indicators to be aware of:

- Attempts to accompany or speak for women partners
- Sexual jealousy or possessiveness
- Psychotic/manic/paranoid symptoms
- Substance use/dependence

It is rare, but a man might present with a physical injury such as a hand injury caused by punching, or you might notice injuries caused by the woman defending herself such as scratches. (Domestic abuse Training Manual for Health Practitioners.)

The Finnish discussion (22.4.2008) suggested that when a man has already used violence against a woman warning signs may include the following: perpetrator is over controlling (answers questions for the woman, doesn’t leave her alone), (professional’s intuition), total denying any problems (no arguments, no jealousy), aggressiveness (defending), use of drugs, mentally ill, earlier violent behaviour, there is violence with someone outside of the family, children are showing distress responses, there is fear. Note: It is very difficult to identify the women as perpetrators.
Topic 3: Interviewing the victim and further appropriate responses

Talking with the victim about violence

As was mentioned before, the first step in intervention is to attempt to develop trust and show caring, non-judgemental support. Do not react with shock when she discloses violence, your surprise at the violence will add to her feelings of isolation and belief that the violence she suffers is unique. Asking about violence can be learned so that it becomes part of normal procedures. By asking about violence a health professional demonstrates professional caring and attention to the well-being of women and children. (Perttu 2000.)

Use questions beginning “How”, “When”, “Who” and supportive statements such as “I am sorry this has happened to you” or “You have really been through a lot” to encourage her to disclose more information. Do not ask victim blaming questions such as “Why don’t you just leave him?” “Did you have an argument before the violence happened?” Reinforce that spousal assault is a crime. Influence her beliefs concerning violence (“I talk too much…” or “He only gets this way when he drinks”); emphasise the batterer’s responsibility for his behaviour. (Perttu 2000.)

There are some examples for asking about violence in a study by Perttu & Kaselitz 2006. These questions help for approaching the victim.

Starting questions:
- “From my experience I know 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 directly affects 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? What has happened and where, when?”
- “Has someone caused these injuries?”
- “The injuries you have suggest to me that someone hit you? Is that possible?”
- “Who has caused these injuries?” “The injuries you have seemed to be caused by an assault. Is this possible?” “According to our experience women get these kinds of injuries often as a consequence of an assault. Who assaulted you?”
Questions when she has brought up the violence herself:

- Estimate her situation and a possible evolution of the violence by using the screening tool (see the topic 1.)
- 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 for the violence).
  - “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, 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?”

Difficult situations

Even when professionals have tools to ask about the violence, there can be difficult situations while interviewing the patient. She can deny everything, or she may be intoxicated, hostile, or hallucinating. She may just want to leave before you have talked with her or you are not speaking the same language.

The following information offers recommendations for difficult situations in health care services while interviewing the patient (Perttu & Kaselitz 2006):

- She denies having been assaulted:
  - Do not insist or pressure her.
  - Tell her what made you think about 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 doubts in your team;
  - Document your doubts and what evidence they are based on.

- She is intoxicated (alcohol, drugs):
  - Minimise talk.
  - 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 a social worker can phone her home later (during next 1-3 days).
She is hostile/abusive:
- Respect her anger. Often the background of the anger is trauma and burn-out from violence. Women may also have failed in help seeking 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 file: 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 stabilise before asking her and talking with 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 a woman’s husband, child, other relative, friend etc. (see topic 1: intervention steps.)
- Use only a female interpreter.

(Perttu & Kaselitz 2006.)

How to ask about the perpetrator

There can be situations when you identify signs that tell you that your patient might be the perpetrator. It is important to react on this if you know how to respond and especially how to ask about violence. There are many similarities between asking victims and perpetrators. However, there are also differences because the situation may be more dangerous with the perpetrator than with the victim.

The following recommendations were developed by the State Province of Southern Finland in co-operation with the Ministry of Social Affairs and Health “How to address violence when you suspect the client is perpetrator”:

1. Ask directly about violence (it is recommended to this together with a colleague);
2. Be sympathetic and open while you are listening to him;
3. Explain that there are many forms of violence;
4. Take a clear stand: say that violence is a crime and you have compulsory notification in certain crimes. Explain that violence has consequences, which can be ruinous for the victim, but also for other family members and himself.
5. Explain that violence and argument are different things and that violence usually continues if nobody is taking action to stop it.
6. Be interested and note the patient’s/client’s own experiences and ideas about violence.
7. Explain that the patient will get help and “bring” him to the services available. Meet him again.
8. Assess the safety of other family members and their need of help.

(Ota väkivalta puheeksi (bring up violence) Etelä-Suomen lääninhallitus, Sosiaali- ja terveysministeriö 2007.)

**Topic 4a: Risk assessment and safety planning**

For a comprehensive risk assessment and safety planning see module 3 for multi-professional training.

**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 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. (Perttu & Kaselitz 2006.)

The American Medical Association (1992) adds the following issues:
- Does she need immediate psychiatric intervention?
- Does she want immediate access to counselling to help her deal with the stress caused by the abuse?
- Does she need referrals to local domestic violence organizations?
**Topic 4b: Referral to supporting system**

If the patient feels it is safe to do so, provide her with *written* information (including phone numbers) on legal options, local counselling and crisis intervention services, shelters, and community resources. Educational materials on domestic violence that are on display in waiting areas and examination rooms may help patients identify violence as a personal health problem. (American Medical Association 1992.)

Local domestic violence shelters and state-wide domestic violence programmes are listed in the phone book. These organisations can help with housing, information about legal rights, welfare applications, and counselling (including peer groups and counselling for children). They may have brochures for distribution to women patients that address issues and list local resources. Many programs offer these services without charge. (American Medical Association 1992.)

---

**References**


Finnish multiprofessional training day (22.4.2008).


Practical part

Topic 1: Intervention steps and screening tools

**Aim:** understanding routine enquiry: learning to ask about violence routinely

**Method:** role play

**Timeframe:** 10 minutes, 30 minutes discussion

**Material:** handout

**Exercise description:**
Worker completes the screening sheet with the victim. Role play based on the handout: Partner violence screening at maternity and child welfare clinics. Observer gives her/his comments after role play.

**Situation:** The victim has arrived at a maternity and child welfare clinic. A staff member will complete the partner violence screening sheet with the victim as part of routine screening. Discussion and form completion takes about 10 minutes (based on experience in practice).

**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 ask further questions.
- You can go through the set of questions while talking. It is still important that the same questions are posed in the same way to all women. In order to do that the questions must be posed (read) as they are on the form.
- Give practical examples; for example, explain what controlling behaviour means.
- Specify the questions if needed.
- You can write the victim’s story on the other side of the screening form: Document the victim’s story by using her words and expressions. Documentation is important for the legal rights and protection of the victim – she might need the documentation later when/if she makes a formal report of an offence. The way you interview and write down the story is important. The woman has the right to read the form that you have filled in and to have a copy of it.

**Parties:** Victim
Worker
Observer

Group discussion after the role play: Victim/Worker/Observer: Comments on questions etc. Gather results on a flipchart at the end of role play: How useful is the safety plan?

- Which questions are helpful?
- Which questions are not helpful?
Notes for the trainer:
Participants work in pairs, one playing the victim and the other playing the staff member. In addition, there needs to be an observer who can comment on the role play afterwards. A bigger training group can be divided into small groups of three persons and roles can be changed, if there is enough time.

Topic 2: Identifying victims/Red flags
Aim: To recognise possible signs of domestic abuse
Method: brainstorming
Timeframe: 20 minutes
Exercise description: small group’s experiences of possible signs.
Notes for the trainer: After discussion the trainer completes the list on the flipchart.

Topic 3: Interviewing the victim and further appropriate responses
Aim: Learn how to ask about violence, intervention
Objective: Response to intimate partner violence
Method: role play
Timeframe: exercise on role play 5-10 (15) minutes, 30 minutes discussion
Material: case study, handout, ppt

Case study 1:
Mary, 19 years, has been beaten by her boyfriend for the first time. She has black marks and bruises. Mary says that the battering happened after a nice restaurant party. The boyfriend said he got jealous during the night because Mary was dancing with other men, too. Mary had noticed before that her boyfriend is possessive and tends to be jealous but she thought that behaviour is normal in the beginning of the relationship. Perhaps there is not yet enough trust in their relationship. And perhaps she had been too happy and sociable at the party.

Case study 2:
Lisa, 35 years, comes to the health centre with her 2 year old son. The son has been restless and crying a lot at night. When discussing this with Lisa, the doctor notices the black marks on her wrists. She hesitates a while but then asks about them. First Lisa says that she got them when carrying her son around the house at night. Lisa seems to be very uncomfortable about the issue and doesn’t want to discuss it further. The doctor says that according to her experience this kind of marks can be caused by physical violence as well. Lisa says nothing and the doctor is afraid that she will rush from the room.
Exercise description:
The worker is interviewing the victim of violence: Role play based on case studies above. Observer gives her/his comments after role play.

Parties: Victim  
Worker  
Observer

Situation: The victim has arrived at the health centre to ask for advice. Discussion takes only 15 minutes (=based on practice experience).

Group discussion after the role play:

Victim: How did I feel?  
Which questions were helpful/ useful and encouraged me to talk more?  
Which questions were not that helpful/ useful?

Worker: How did I feel in my role?  
What was the most difficult for me?  
What did I handle well?

Observer: Comments on questions etc. Gather results on a flipchart at the end of the role play.

- Useful questions for the victim  
- Questions those were not useful

Notes for trainer:
One of each pair plays the victim and the other plays the staff member/worker. There should be an observer to give feedback at the end. A bigger training group can be divided into small groups of three persons. Parties can change roles, if there is enough time.
Topic 4: Responses to intimate partner violence

Role play after disclosure: How to work with “Referral” and “safety plan”

Aim: To respond appropriately to disclosures of violence
Objective: 
Method: role play
Timeframe: exercise with role play 15 minutes, 30 minutes discussion
Material: Handout
Exercise description: 
Worker develops a personal safety plan with the victim. Role play based on the handout: personal safety plan. Observer gives her/his comments after the role play.

Situation: The victim has arrived at the health centre to ask for advice. The staff member/worker will develop a safety plan with the victim. Discussion and development of plan takes about 15 minutes (=based on practice experience).

Parties: Victim
Worker
Observer
Group discussion after the role play: Victim/Worker/Observer: Comments or questions etc. Gather results on a flipchart at the end of the role play: How useful is the safety plan?

- Useful questions
- Questions that were not useful

Notes for trainer: 
One member of each pair plays the victim and the other plays the staff member/worker. There should be an observer to give feedback at the end. A bigger training group can be divided into small groups of three persons. Parties can change roles, if there is enough time.
Handouts:

Topic 1: Intervention steps and routine enquiry

Further recommendations for intervention

- Health professionals’ most important task is to assure that a client’s experience is acknowledged and her feelings about the violence are validated. The professional’s role is important in supporting patients’ work through their experiences.
- Show that you believe the client’s story and what has happened to her. Passive listening and none commenting makes her doubt what has happened and can make her think that she is wrong and the others are right including the assaulter.
- In addition to physical and sexual violence it’s important to pay attention to psychological violence and on the partner’s use of power and control. The health professional’s role is to support the women to recognise what is happening to them.
- Ask and listen to her experiences if she has sought help earlier. In case she has 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 (for example about burnout, impacts on physical health)
- Discuss beliefs related to violence. Give information on the facts: prevalence of violence against women, woman is not guilty of nor responsible for the 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.
- Guide and help the woman to go to the doctor’s reception even if you only suspect physical and/or sexual violence. Tell her that a doctor’s visit and statement is relevant for her legal protection.
- Estimate victim’s needs 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 order
  - Discuss reporting an offence if she is physically or sexually assaulted.
  - Tell her about the importance of collecting evidence. Doctor’s 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 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 assaulter 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 the presence of their parents.

(Perttu & Kaselitz 2006.)
**Topic 1: APPENDIX**

**PARTNER VIOLENCE SCREENING AT MATERNITY AND CHILD WELFARE 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.

*When asking these questions, no persons should be present other than the interviewer and interviewee.*

Circle the answers given by the interviewee.

1. **Does your partner sometimes behave in a manner that makes you afraid of him?**
   - 1 yes
   - 2 no

2. **Does your partner behave in a derogatory, humiliating or controlling manner towards you?**
   - 1 yes
   - 2 no

3. **Has your current partner**
   - Yes
   - No
   - 1 Threatened you with violence (incl. threat to use a weapon/object)?
   - 2 Grabbed, pulled, pushed, slapped or kicked you?
   - 2 Used some other form of physical violence against you? If so, what?
   - 2 Pressured, forced or attempted to force you into having sex?

4. **When did your current partner behave violently?**
   - Yes
   - No
   - 1 During the past 12 months
   - 2 During pregnancy
   - 2 After the child was born

5. **Has your current partner been violent towards your child/children?**
   - 1 yes
   - 2 no

6. **Have any of your children been watching or listening when your partner has behaved violently?**
   - 1 yes
   - 2 no

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

Copyright: Sirkka Perttu 2003

PRO TRAIN: Improving multi-professional and health care training in Europe – Building on good practice in violence prevention
Topic 2: Identifying victims of intimate partner violence

Warning signs of domestic abuse in women

- A woman arrives at the maternity care at a later stage of pregnancy than usual.
- A pregnancy is not planned and/or is undesired.
- She seems busy and anxious.
- She cancels/forgets appointments.
- She looks untidy.
- Her life / family life is characterised by social isolation/she has only 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 previous 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 a 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, and belly.
- She shows psychosomatic symptoms like different pains, insomnia, nightmares, eating disorders, unusual changes in weight.
- 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.

(Perttu & Kaselitz 2006.)
Topic 3: Interviewing the victim of violence

Key issues in addressing violence in health care settings - The role and responsibilities of health care providers

The most important responsibilities for health professionals are:
- recognise violence
- support the victim
- document the violence and its impact (injuries, psychological impact, etc.)
- refer to other services
- co-operate with other professionals

The following is essential when wanting to really help and support victims of domestic/partner violence:
1. The first step in intervention is to attempt to develop trust
2. Show caring, non-judgmental support
3. Do not react with shock when she discloses violence; your surprise at the violence will add to her feelings of isolation and belief that the violence she suffers is unique
5. Supportive questions such as “I am sorry this has happened to you” or “You have really been through a lot” encourage her to disclose more information
6. 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?”
7. Reinforce that spousal assault is a crime; do not blame the woman
8. Influence her beliefs concerning violence (“I talk too much…” or “He only gets this way when he drinks”); emphasise the batterer’s responsibility for his behaviour
9. Give the victim information about violence, e.g. its frequency and the dynamics
10. Discuss with her resources and options
11. Search together for the services best suited to her needs
12. Leave the door open for her to come back to you

(Perttu and Kaselitz 2006.)
Topic 4: APPENDIX

Personal Safety Plan

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 below) which you can give to her. It helps mother and children feel in control of the situation. Some of the consequences of violence can also be alleviated or avoided by the safety plan. If a woman returns to the violent partner it is even more important to prepare a safety plan. In case the woman is about to divorce/separate/move out, the safety plan is essential.

1. If my own or my children’s safety is in danger at home, I can go to ______________________ or ______________________ or ______________________ (decide this even if you do not expect another violent act)

2. In a violent or threatening situation a safe way out of home is ______________________ (for example which doors, windows, elevator, stairs or emergency exit I could use).

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

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

5. If my partner doesn’t 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 friends’ home) ______________________

7. I need the following things in case of a quick departure from home (content of the safety bag):
   - Money/cash
   - Extra pair of home keys and car keys
   - Extra clothes
   - Personal hygiene items
   - Important phone numbers, phone card
   - Medical prescriptions
   - Important documents/cards (health insurance-, identity card etc.)
   - Children’s favourite toys

   PRO TRAIN: Improving multi-professional and health care training in Europe – Building on good practice in violence prevention
8. The worker/staff member has told me that
   - I am not responsible for the violent behavior of my partner but I can decide how to improve my and my children’s safety.
   - I deserve better than this: I and my children have the right to a safe life without the fear of violence.
   - Violence is a crime and I can report it to the police.
   - Restriction order and how to apply for it
   - Places where to get support:

9. The worker/staff member has suggested/we have agreed that I can continue to discuss the issue at the following place / with professionals at:

10. Together with the worker/staff member I have made a (written) assessment of the violence. In my situation answers mean that

11. I can keep this safety plan without endangering my own or my children’s lives.

(Perttu 2004.)