FAMILY VIOLENCE
CLINICAL GUIDELINES FOR NURSES

CANADIAN NURSES ASSOCIATION OF CANADA
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

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INTRODUCTION

Members of the Canadian Nurses believe that family violence is a major health problem issue. We also believe that nurses must take a proactive family violence.

Violence must be recognized as the exercise of power and control over more vulnerable individuals or groups. All forms of violence are interconnected, but children and older adults are particularly vulnerable. It is recognized that violence also occurs against male partners.

Family violence is a broad term that encompasses all forms of abuse. Violence has a profounded impact on all segments of society and affects all family members. Violence within families, especially abuse of women is not new, but has been entrenched for centuries in social institutions such ass courts, health care organizations and churches. Tolerance for family violence can be viewed as society's attempt to preserve the family unit (i.e. the status quo) at the expense of the physical, mental, spiritual and emotional well-being of individuals.

The prevention and identification of abuse and subsequent intervention are important areas for nursing involvement. Nurses are often the first professionals to interact with those affected by family violence. As members of the interdisplinary health care team, we can play a significant role in addressing this issue.

There may be a reluctance on the part of the nurses to intervene because of the perception that violence is a private, family matter that a social health problem. This perception may be shared by health care administrators who may not support nursing interventions. In addition, nurses may be uncertain what to say or do when a client acknowledges that abuse has occurred.

Canadians are no longer willing to condone family violence. As a result, the helping professions recognize the need to offer effective assistance to families who are living with violence.

These guidelines are designed to provide current information about abuse and to address prevailing myths; to provide clear direction to nurses in a variety of settings; and to raise the awareness and comfort level of individual nurses as we deal with this complex issue.

PRINCIPLES

- Everyone has the right to live a life free of violence.
- No one deserves to be abused physically, sexually, emotionally or financially.
- No one has the right to control another person by threat, coercion, physical intimidation or by any other misuse of power.

ASSUMPTIONS

- It is the responsibility of every nurse to be an advocate on behalf of any client suspected of being a victim of abuse.

- Abuse is a concern best addressed by a wide variety of health care personnel, according to particular areas of expertise.

- Nurses must be involved in developing policies to address abuse.

- Individuals are the experts in their own lives and usually make decisions that they perceive as best for themselves.

MYTHS AND FACTS

There are some general myths about the victims that we need to address.

Myth: *Abuse occurs more frequently in certain racial, cultural or economic backgrounds.*

Fact:

Abuse of women by their intimate partners occurs at all levels of society and in all races The two main results of believing in this myth that certain cultures are being seen as violence, and that within certain cultural groups may be even less likely to be identified. It is important that persons accurately identified as victims of family regardless of their backgrounds.

Myth: *Violence is usually caused by alcohol or drugs.*

Fact:

Violence is not caused by alcohol or drugs. This extremely dangerous myth encourages a view of perpetrators as not being responsible for their actions because of impairment. Abusers may drink to excuse their actions. Health care professionals may see the addiction as the major problem and miss the abuse entirely.

Myth: *Women must enjoy violence or they would leave.*

Fact:

Women do not enjoy violence. They hope for an end to the violence and hope that the good times between violent incidents will continue. Women frequently stay in violent situations because they believe it is the best thing for their children and that the children need a father. It is also common for a man to threaten his partner with violence, death, child-snatching and/or of obtaining child custody if she leaves him. Women are quite correct to take these threats seriously.

Studies show that 60 percent of all female homicides in Canada are committed by persons with whom the victims are intimate. The most dangerous time occurs when the woman chooses to leave her abuser, or when she state that she is ending the relationship. Women may deny the abuse, often at the expense of their self-esteem, independence of life. Fear is the most compelling reason women stay in or return to a violent relationship.

Myth: *The violence can't be too bad or women would not return.*

Fact:

Women return for a variety of reasons. They may return hoping the violence is over. Usually partners are remorseful and promise that the violence will not be repeated. Children are usually lonely for their father and their home and often try to persuade the mother to return. A woman whose self-esteem has been repeatedly attacked may doubt her ability to cope with raising her children on her own. After a short time away from her partner she may begin to realize how little support, either financial or emotional, she can expect through the legal or social service systems. The reality is that women must often condemn themselves and their children to a life of poverty as the price for escaping violence. On the other hand, there may be a sense of relief once the decision to make a change has been taken.

Myth: *Abuse is a private matter between a man and his partner and is no one else's business.*

Fact:

Violence may be transmitted inter-generationally. Some abusers and abused have grown up in abusive homes. Child witnesses violence between parents are at great risk of growing up to be either abusive or abused. Subsequently, abuse may be continued through the learned behaviour of children. The need to break this cycle is a major societal concern and as such, is everyone's business.

Assault is a criminal offense in Canada.

Myth: *Women provoke men into abusing them.*

Fact:

Abusers are responsible and accountable for their own actions. Resorting to violence to express angry feelings is unacceptable. There is no excuse for abuse.

Myth: *Older people are "burdens" or inconveniences to their families.*

Fact:

Although many older people depend on their families for certain kinds of support, in many cases the relationship is one of mutual assistance between generations. For example, a daughter may pick up groceries for her parents, but she may regularly eat supper at their hoe. In many families their is a mutual dependency that does not lead to abuse or neglect.

CLARIFYING OUR OWN VALUES, FEELINGS AND BELIEFS

We must be aware of our own feelings about family violence if we are to fully assists victims. Nurses who are unclear about their own feelings about family violence may deny its existence, blame the victim in crisis and minimize the effects of the violence.

Nurses are often witnesses to violence or may themselves be victims. This may affect the nurse's response, because of the need to distance yourself from the potential of your own abuse. Nurses may feel vulnerable, overwhelmed and powerless when faces with helping clients who have been abused. In order to be helpful, nurses need to understand that they are not alone and can get help form their colleagues. As we increase our knowledge about family violence, we can come to terms with the intensity of feelings it generates. A clearer understanding of the complexity of the situations emerges as well as an increased respect for those living in violent situations.

IDENTIFICATION/ASSESSMENT

Some cases of family violence present as obvious abuse and the client may openly acknowledge the problem. Other clients deny that their injuries or symptoms are related to family violence, despite indicators to the contrary.

Assessment includes comprehensive history taking, observation and physical assessment. The incorporation of family violence screening questions into all nursing database intake tools and/or history forms will facilitate this process.

Identification of family violence involves becoming familiar with abuse indicators. Examples of indicators of family violence are contained in Appendix I. Abuse of women is often accompanied by neglect of basic health needs and financial deprivation, even if the abuser has adequate financial resources. Victims may suffer from nutritional and sleep deprivation, as well as emotional trauma. Examples of common health concerns experienced by abused women and children include neglect of basic immunization, follow-up Pap smears and breast lumps; untreated sexual transmitted diseases or yeast infections; and frequent premature discontinuation of prescriptions for antibiotics. Abuse during pregnancy is common and includes blows to the abdomen and/or sexual assault. This abuse may result in complications such as preterm deliveries, miscarriages and stillbirth. In a family where the mother is abused, children may also be abused.

Family violence should be explored with all clients, regardless of gender or age. Clients will not usually be upset bout being directly questioned. Straightforward, open-ended questions asked in a nonthreatening and nonjudgmental manner will help decrease the stigma associated with abuse. Clients may avoid discussions because questions are painful, embarrassing or provoke anxiety. Structure the interview to systematically elicit more data, thus allowing the client to tell her own story.

In order to make it safe to discuss the problem, statements about the frequency of family conflict and aggression may be used: "Many times, families don't handle problems in the way that they would like to. How does your family handle problems? Has anyone ever use physical force? Who? When? Take

notice of vague or evasive answers. Ask for clarification of vague answers, and pursue areas in which the client is evasive. If their is an indication of family violence, explore further: "What happens when you and/or your partner gets angry? or "Has anything happened to you that might have caused these symptoms?"

Assault is a crime everywhere in Canada.

INTERVENTIONS

The scope and depth of the interventions may vary from situation to situation. The goals are

- to empower the client to take control;
- to provide support; and
- to maximize safety.

Interventions will be influenced by the age of the client, the initial reason for nurse-client contact and the opportunity for ongoing contact. The choice of intervention will depend on a variety of factors, which may include

- support services in the community;
- experience and skills of the nurse;
- work setting;
- the willingness of the client to seek/accept help from other agencies/service providers.

For these reasons, the interventions outlined in this document are meant to be used only as guidelines. Some interventions are routinely performed by nurses. Others are interventions that nurses with special preparation or education in communication and group facilitation perform in a variety of work settings. Disclosure of abuse, in particular child sexual abuse, will probably produce a family crisis.

PRINCIPLES

ABUSE OF WOMEN

- Victims have the right to the least intrusive intervention. People will accept help when they choice not to accept help must be respected.
- Intervention should be aimed at maximizing the person's options.
- Intervention with adults can only be undertaken with their voluntary and informed consent.
- Disclosure of abuse is complicated by fear, ignorance and embarrassment. The abused person may feel vulnerable and indecisive, and show low self-esteem. Most clients are very vulnerable at the time of disclosure, or can be in a state of emotional shock that may last several days. During this time many clients are overly compliant to suggestions and may later blame the nurse for giving advice. The nurse listens, allows time for the client to ventilate feelings, offers emotional support and avoids telling the client what to do.

- The ethonocultural reality of the client must be acknowledged. Some clients are especially vulnerable because if existing family violence information and programs may be inaccessible or inappropriate for their needs.

- People do have the capacity for positive change.

Short-Term Interventions

- Assess the immediacy of danger: "Are you concerned about your safety? Are your children safe?"

- If abuse is strongly suspect or acknowledged, share your concerns with the client: "I am concerned about your safety."

- Convey to the woman that she is non to blame and has the right to be safe. Ask her if she would like to contact the police: "Assault is illegal. Do you wish to press charges?" Be aware that policies on pressing charges may vary across the country.

- Explore options: ""Do you need help?"

    — "Who knows about the violence?"

    — "Do you have family or friends who can support you right now?" "Do you have money, credit cards, access to a bank account?"

    — "Is it safe for you to go home right now?" If not, "Do you have another place to go to that is safe?"

    — "Do you know what a shelter is?" "Would you consider staying in one?"

- Give appropriate referral information: shelters, housing options, legal assistance, financial assistance, distress/help-lines and police contact. Give written information whenever possible.

Note: This may be your only contact with the client; therefore, it is essential that information regarding available services be provided during this contact.

- Respect the client's decisions, keeping in mind that ultimately the decision to accept help is a personal one. The client may believe that she should return to the abusive situation for a variety of reasons. If there are children involved, it is appropriate to explore with the client the possible impact of violence on the children.

- If the client decides to return to the abusive situation, help her to develop a safety plan so that she will be prepared if she has to leave again in the future.

A safety plan may include, but is not limited to

    - a plan for an escape route;

- establishing a personal and separate bank account in a different bank in her own name;
- storage of a suitcase in a safe place outside the home. The suitcase should contain
- a change of clothes for the client and each child;
- copies/photocopies of essential documents such as her marriage license, children's birth certificates, medical insurance number, and, if possible, her last income tax return;
- a toy for each child;
- a small amount of money; and
- essential telephone numbers.

The planning process has the additional benefit of making it clear to the woman that although you can support her decision to return, you do not expect the violence to end. It may be important for her to remember this fact when the next violent incident happens and she may be told by the abuser that the abuse is her fault.

Clients may deny abuse even though all the evidence indicates it is occurring. It is common for nurses to feel frustrated; therefore, it is important that they access personal or professional support when needed. By expressing concern you are communicating your support and willingness to help. This may bring the client one step closer to dealing with the problem. As in any situation involving assistance, the client is the expert on what is the best decision for her. The nurse's role is to help the client make decisions, not to solve the problem for her.

Long-term Intervention

Even if a violence-free setting has been established, some women and children may still need ongoing intervention, such as counselling or help in making visitation rights. At this stage, counselling may be provided by nurses and others with expertise in the area. goals of ongoing counselling may include

- continuing to choose to be safe from violence;
- improving quality of life through increasing self-esteem;
- exploring options for self development.

ABUSE OF CHILDREN

Child abuse is the mistreatment or neglect of a child by a parent, guardian or caregiver that results in injury or significant emotional of psychological harm to the child.

Child abuse is expressed in several different forms:

- physical abuse
- sexual abuse
- neglect
- emotional abuse

All children living in homes where violence occurs are affected by it in some way. These children are vulnerable to all forms of physical, sexual and emotional abuse. In addition, they are particularly vulnerable to neglect, emotional difficulties and physical injuries sustained while attempting to protect other family members. For specific indicators of child abuse, refer to Appendix I.

Consider the following facts:

- Child abuse is not confined it cuts across all ethnic, religious, social and economic backgrounds.
- Potentially the most serious cases of child abuse involve preschoolers or infants.
- The pressure to be seen to be dating can be a powerful motivation for young people. Many victims of dating violence may believe that having an abusive partner is better than not having a partner at all. Nurses must be aware that young people in dating relationships are also vulnerable to abuse.

Reporting of actual and suspected child abuse is mandatory across Canada.

Disclosure of abuse when children are involved is challenging. Specific guidelines for handling children's disclosure of abuse are available and should be used. For example, refer to "Handling Disclosures" in Child Sexual Abuse Guidelines for Community Workers.

Intervention

- When child abuse is suspected, follow the established protocol for mandatory reporting.
- Allow the child to talk, and protect the child from having to give multiple reports.
- Reassure the child that you believe the story.
- Reassure the child that he/she has done nothing wrong.
- Do not make critical comments about the abuser.
- For further information, refer to the section on documentation. For support services, contact the local

— child welfare agency

— police department

— social service agency

— hospital

— mental health centre

— distress centre

— other community service organizations that provide counselling and support to children and families

ABUSE OF OLDER ADULTS

Abuse and neglect can be defined as any action/inaction that jeopardizes the health or well-being of an older person. The abuser may be a relative or person in a position of trust. A relative can be a partner, sibling or child. A person in a position of trust can be a neighbour, home care worker or staff person in a care facility.

Abuse of older adults is expressed in different forms:

- physical abuse
- psychological or emotional abuse
- financial abuse or exploitation
- sexual abuse
- medication abuse
- violation of civil/human rights
- active or passive neglect

The abuse and neglect of older Canadians does not only occur within private dwellings in our communities. It may also occur in institutions such as senior citizens' homes, hospitals, nursing homes and chronic care facilities. For specific indicators of abuse of older adults, refer to Appendix I.

Abuse of older adults affects both sexes. While there are many contributing factors, abuse of older adults may be a continuation of earlier abuse experiences that occurred during childhood or young adulthood. Many older people remain in abusive relationships for the same reason younger people do. Older clients may be more likely than younger ones to feel that it is too late to start a new life.

Incidents of abuse of older clients who reside in institutions have increasingly been reported. Inform

yourself of provincial legislation and legal policies related to abuse. In some jurisdictions, reporting of abuse of older adults is mandatory while in other jurisdictions reporting is voluntary. The reporting issue is a complex one.

Older people may not disclose abuse and neglect because of

- a lack of awareness that what they are experiencing is abuse or neglect;
- a fear of the abuser;
- a fear of being sent to an institution;
- a lack of awareness of agencies that can assist;
- a lack of financial resources;
- a lack of mental disorder, which makes reporting difficult or impossible.

Intervention

- Every situation involving suspected abuse and neglect must be assessed individually to determine what the older person wants and the degree of intrusion warranted. Situations will vary in degree of risk for the adult person.
- Older adults are entitled to be presumed competent and capable of making decisions for themselves. They are also entitled to support and assistance in order to understand and make informed decisions on their own behalf.
- It is essential to establish a positive relationship with the older person and the family member, caregiver or abuser. For example, pressures resulting from overwhelming responsibilities can often be lessened and dealt with when those involved feel acceptance.
- Inform the client of his/her rights.
- Explore with the client options for maximizing independence, such as medical alert services; aids for keeping in touch such as the radio; and maintaining social contacts.
- Explore the need for additional services in the home such as home care, public health nurse, respite care. visiting home-makers or Meals on Wheels. (Familiarize yourself with these-services in your area)
- Explore alternate living arrangement possibilities.

ABUSE PREVENTION

Nurses play a fundamental role in family violence prevention because of our focus on wellness and the diversity of areas in which we practice:

- maternal/child health
- community health
- school health
- mental health
- occupational health
- nursing homes and institutional care
- acute care
- primary health care
- academic settings

Within all practice areas, nurses must take a proactive role in dealing with family violence prevention and early screening of vulnerable individuals and family members. The incorporation of family violence screening questions into all nursing intake tools and/or history forms will be an important step (see Appendix II).

This prevention role for nurses includes promoting a shift in attitudes, values and beliefs directed toward the elimination of family violence. Some of the dimensions of family violence prevention include

- review of our own attitude and beliefs;
- in-service training and education;
- curricula development;
- advocacy in program and policy development.

REFERRAL

Collaborative approaches to family violence intervention promote a better understanding of issues, ensure more comprehensive service to the client and lead to a better use of resources. Interprofessional confidentiality can be maintained by establishing specific guidelines within your organization(s) to deal with this issue. Nurses in all practice areas can keep an updated list of professional and community resources. Without this, care may be fragmented and interventions incomplete.

Provide specific information to the client about how to contact

- transition houses or emergency shelters
- the police
- social services
- medical care
- legal services
- women-centred counselling services
- support groups (for victims and abusers)
- women's centres
- native centres
- telephone help lines
- agencies servicing specific population groups
- other agencies that are available in your area

Note: Assist the woman to find the most appropriate counselling for her needs. Couples counselling is dangerous at this time; therefore it is not recommended.

DOCUMENTATION

Document quotes, observed behaviour, physical assessment and interventions. Write fact, not opinion. Judgemental statements could unfairly influence custody decisions and/or jeopardize your client's case.

- Document accurately, specifically, and in detail what was said, done or observed
- Notes may be required for court purposes; therefore, date, time and direct quotes of what the client said are important.
- Record these notes as soon as possible after the interaction.
- Record content of all interviews with client, family, caregivers and others.
- Document both physical and psychological symptoms. Be objective and quote the client. tools such as body maps (Appendix II) can be used to graphically describe location, pattern and distribution of physical injuries. If possible, and with the client's permission, take photographs of any physical injuries for the permanent record. Comprehensive documentation of injuries will indicate if their is a reoccurring pattern of violence, and constructive action can be taken.

CONCLUSION

These guidelines were developed as a tool for nurses. The concepts in the guidelines may be used in any setting. It is essential we collaborate in the development of policies, procedures and protocols to address issues of family violence.

The role of nurses must be clearly defined and supported by the employing organizations or agencies. Such support will increase the effectiveness of intervening and supporting families who live with violence.

Nursing schools must develop curricula content to include education related to family violence. At the service level, continuing education departments need to develop support systems for nurses, such as critical incidence stress debriefing and employee assistance programs.

Lobbying strategies aimed at securing optimum economic and human resources will further assist nurses as they accept the challenge of working in the area of family violence.

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APPENDIX I

CHECKLIST OF ABUSE INDICATORS

Abuse Indicators for Children

Physical

☐ 1. Self-mutilation

☐ 2. Injuries to bone or soft tissues

☐ 3. Fractured skull or subdural haematomas

☐ 4. Retinal haemorrhage

☐ 5. Joint dislocations

☐ 6. Bruising to torso, buttocks or head (may take the shape of object used, such as belt or hand)

☐ 7. Bite marks

☐ 8. Burns with irregular etiology such as stove top or cigarette

Psychological

☐ 1. Withdrawn behaviour, especially girls

☐ 2. Infants may show lack of fear of staff and/or rocking behaviour.

☐ 3. Boys may be unusually aggressive and destructive/abusive

☐ 4. Delayed speech and learning disabilities

☐ 5. Unusually mature for age; responsible

☐ 6. Low self-esteem

☐ 7. May appear to be living in poverty

☐ 8. May appear afraid of parent figure

☐ 9. Depression, suicide attempts, alcohol or drug abuse

☐ 10. Psychosomatic illnesses such as abdominal pain

☐ 11. Secretive, fears reprisal

☐ 12. May divulge violence towards pets

☐ 13. Feels at fault for injuries: I was bad, I deserved it"

☐ 14. Runs away from home

☐ 15. School performance changes

☐ 16. Stealing

Sexual

☐ 1. Unusually mature knowledge of sexual terminology and slang

☐ 2. Perineal rashes, frequent gastrourinary tract infections

☐ 3. Sexually transmitted diseases in pre- or postpubertal children

☐ 4. Evidence of anal or vaginal penetration by foreign body

☐ 5. Juvenile prostitution

☐ 6. Teen pregnancy

☐ 7. Juvenile sex offender

☐ 8. Promiscuous sexual behaviour or activities

Signs of Neglect

☐ 1. Low birth weight

☐ 2. Failure to thrive

☐ 3. Underweight for age

☐ 4. Anaemia

☐ 5. Poor hygiene

☐ 6. Improper dress for the weather

☐ 7. Poor resistance to disease

☐ 8. Child appears repeatedly at health care facility. Injuries may increase severity each time. May show combination of old and new injuries as bruising

☐ 9. Medications not given properly or at all.

☐ 10. Injuries sustained do not fit history given by child or caregiver

Abuse Indicators for Older Adults

Physical

☐ 1. Physical or mental impairment

☐ 2. History does not coincide with injuries

☐ 3. Old injuries and partially healed injuries

☐ 4. History of multiple doctors or treatment centres

☐ 5. Pressure sores

☐ 6. Poor mouth care

☐ 7. Missing dentures

☐ 8. Missing glasses

☐ 9. Poor physical hygiene

- ☐ dried faeces

☐ 10. Over/under medicated

☐ 11. Weight loss

☐ 10. Dehydration

☐ 11. Caregiver shows unrealistic expectations of older adult's capabilities

☐ 12. Bony or soft tissue injuries

☐ 13. Unkempt appearance

- ☐ hair
- ☐ unshaven
- ☐ long fingernails

Psychological

☐ 1. Avoids physical or verbal contact with caregiver or nurse

☐ 2. Allows caregiver to answer for him or her

☐ 3. Delays in seeking medical attention

☐ 4. Refuses medical treatment

☐ 5. Agitation, depression or overly quiet

☐ 6. Avoids eye contact

☐ 7. Cringing or rocking behaviour

☐ 8. Poverty (abused financially by caregiver)

☐ 9. Caregiver may verbally humiliate older adult

☐ 10. Blames self for the attitude of caregiver

☐ 11. Fears abandonment and reprisal from caregiver

☐ 12. Caregiver may treat elder as a child

☐ 13. Caregiver may excessively restrain or isolate the older adult

☐ 14. Family member/caregiver may be alcohol or drug abuser

☐ 15. Social isolation

Sexual

☐ 1. Bruising or lacerations of genitals

☐ 2. Sexually transmitted diseases

Abuse Indicators for Women

Physical

☐ 1. Injuries to bone or soft tissues

- ☐ lacerations to head or face
- ☐ hair loss
- ☐ broken teeth

- ☐ fractured or dislocated jaw
- ☐ black eyes
- ☐ perforated eardrums

☐ 2. Abdominal, breast or perineal bruising, especially if pregnant

☐ 3. Bite marks

☐ 4. Unusual burns caused by

- ☐ cigarettes
- ☐ top of stove
- ☐ hot grease
- ☐ acids

☐ 5. Injuries sustained do not fit the history given

- ☐ client appears after hours
- ☐ client delay coming for treatment

☐ 6. Client may show evidence of old or new injuries

☐ 7. Visits to facilities may increase and severity of injuries become more serious over time

☐ 8. Nutritional/sleep deprivation

(Forty percent of women who are physically abused by their spouses are sexually abused)

Psychological

☐ 1. Depression

- ☐ low self-esteem
- ☐ withdrawn
- ☐ unkempt appearance
- ☐ may discuss or attempt suicide
- ☐ anorexic or bulimic behaviour

- ☐ alcohol or drug abuse
- ☐ insomnia
- ☐ psychosomatic illness (may be noncompliant)
- ☐ anxiety attacks
- ☐ feelings of helplessness
- ☐ cries frequently
- ☐ indecisive behaviour
- ☐ avoids eye contact

☐ 2. Loss of family and peer contact

- ☐ feels isolated

☐ 3. Poverty (May be due to economic entrapment by partner)

☐ 4. May minimize or delay treatment of injuries for self or child

☐ 5. May refuse further investigation or intervention with self or child

☐ 6. May feel abuse is her fault ("I asked for it")

☐ 7. Fears reprisal

☐ 8. May show detachment or hostility toward children herself

☐ 9. May have unrealistic expectations of children's development and capabilities.

Sexual

☐ 1. Sexually transmitted disease

☐ 2. Vaginal and/or rectal bruising or tearing

☐ 3. Miscarriages

☐ 4. Stillbirths

☐ 5. Pregnancy

☐ 6. Preterm babies

☐ 7. Low birth weight babies (abused women have an increased tendency to deliver low birth weight babies)

Abuse Indicators for Abusers

Physical

☐ 1. May show signs of victims fighting back

- ☐ facial scratches
- ☐ injuries to hands

☐ 2. May display rough handling of children

☐ 3. May display unrealistic expectations of children's abilities and behaviours.

Psychological

☐ 1. Tends to show up in emergency room with injured partner

☐ 2. Hovers and is unwilling to allow private interview

☐ 3. May minimize injuries of partner or child

☐ 4. Feels injuries were "asked for" and not his fault

☐ 5. Family tension may be evident between spouses/children

☐ 6. Tends to be jealous of partner: "Can't trust her or anyone else"

☐ 7. Has rigid ideas about male and female roles

☐ 8. Feels women and children need to be "kept in line"

☐ 9. May be verbally abusive to others

☐ 10. Shows varying degrees of contempt for women

☐ 11. Views partner and children as property

☐ 12. May have been raised in a dysfunctional or abusive family

☐ 13. Wants people to see him as the victim

☐ 14. May blame alcohol or drugs for his behaviour

☐ 15. tends to be unable to control his angry outbursts

☐ 16. May give appearance of being a "really nice guy

☐ 17. May be manipulative

- ☐ shows up with flowers for abused partner
- ☐ threatens or attempts suicide
- ☐ threatens to kill partner/children if partner attempts to leave him

☐ 18. Vague or evasive when asked about injuries of partner or child

☐ 19. Delays or refuses treatment

Sexual

☐ 1. Shows little respect for women's wants or needs sexually:

"No woman can be raped if she doesn't want it"

☐ 2. May engage in polygamous relationships

☐ 3. May feel that child sexual abuse was "asked for by the child," that the child "seduced him"

APPENDIX II

SAMPLE TOOL

Abuse Assessment Screen

1. "Have you ever been hurt, physically or psychologically, by someone close to you? If yes, by whom and how often? Have you ever hurt someone close to you? If yes, whom and how often?"

2. "Within the last year, have you been hit, kicked, slapped or otherwise physically hurt by someone? If yes, by whom and how often?"

   "Have you physically hurt someone? If yes, by whom and how often?"

3. "How has the abuse affected your life to date?"

4. "How do you feel about the abuse?"

5. "What do you know about family violence in general?"

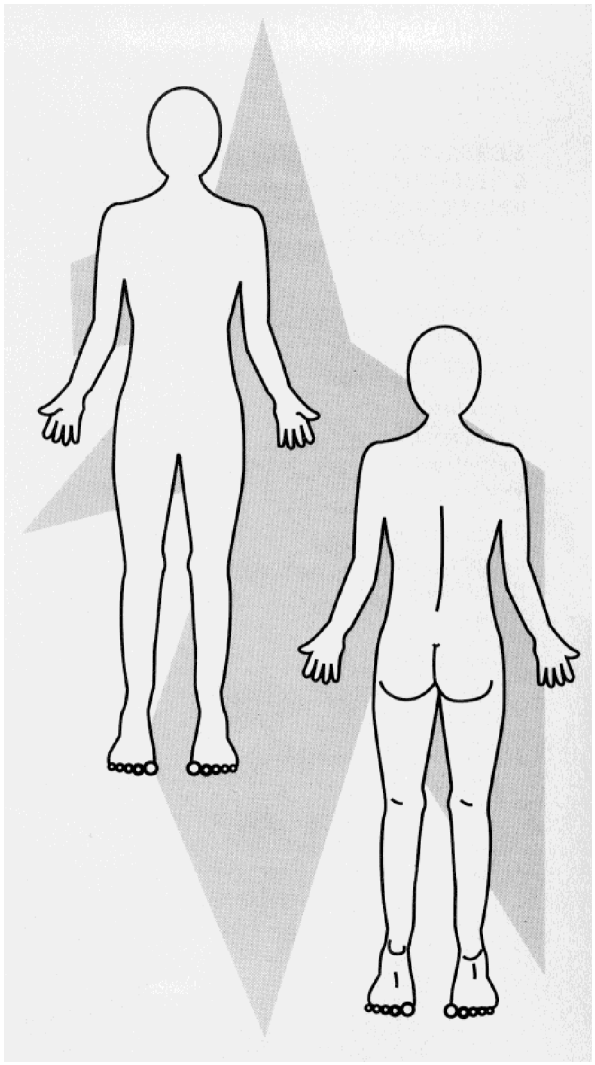
6. "Do you know what resources are available to you?"

7. Physical assessment (Mark the area of injury on the body map and describe):

8. Mental status examination:

9. Safety concerns?

10. Intervention/referral:



APPENDIX III

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Family Violence Clinical Guidelines/Protocols for Nurses

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FAMILY VIOLENCE CLINICAL GUIDELINES FOR NURSES

To assist us in meeting your needs we would appreciate you taking a few minutes to provide us with feedback on this document.

1. How do you think the information in this document could be used?

2. Have you used the information in this document? How?

3. What information was most valuable to you in your work setting?

4. What recommendations would you make for inclusion of additional information in these guidelines?

5. Have you shared these guidelines with anyone other than another nurse?

   Yes ☐ No ☐ If yes, with whom?

6. What type of support from us would you find helpful in incorporating this information into your practice settings?

Thank you for your feedback.

Please send completed questionnaire to

The Canadian Nurses Association
50 The Driveway, Ottawa, Ontario, K2P 1E2

DIRECTORY OF LOCAL SERVICES