

**OBJECTIVE**

Increase Alberta physician awareness of issues relating to violence  
Provide resources for the identification and management of suspected violence

**TARGET POPULATION**

All Albertans

**EXCLUSIONS**

None

## RECOMMENDATIONS

### RECOGNIZE

- ✓ Look for **fear** to identify unhealthy relationships where violence and abuse can occur
  - Ask to understand
  - Listen to learn
  - Watch for the use of fear to control
- ✓ **Ask:** Does anyone make you feel afraid?

### RELATE

- ✓ Build respectful relationships with three key questions:
  - What are your thoughts about....? (Readiness to change)
  - How would your life be better if.....? (Benefits of change)
  - Is anything standing in the way of making this change? (Barriers to change)

(See the supplement to the DOVE CPG: [Motivational Interviewing with Survivors of Violence: A Reference Guide<sup>1</sup>](#))

### REFER

- ✓ Offer choices – “would you like to come back to discuss this again or would you like to talk with an expert in these matters?”
- ✓ See [Appendix A](#) - Resources specialized in assisting with the next steps:
- X Do not contact police without consent – adult victims must agree to contact authorities when and if they choose.
- ✓ Reporting is mandatory if a child is suspected or confirmed to:

- Have experienced violence or abuse
- Witnessed violence or abuse
- Be at substantial risk to be physically or sexually abused
- Have a guardian who is unable or unwilling to protect a child from physical injury or sexual abuse
  - Report to:
    - Province wide except Calgary: 1.800.638.0715
    - Calgary: 403.297.2995
  - For more information contact the Family Violence Information Line: 310.1818
- ✓ Reporting connects to resources and assistance

## BACKGROUND

### DEFINITIONS

#### **VIOLENCE**

“Violence is any action, inaction, or threat, regardless of intent or intensity that results in either physical or psychological injury to an individual, family, or community.”<sup>2</sup>

- Violence has no minimum intensity since there is no lower limit of harm that can be accepted.
- Good intent (discipline, spanking or “teaching a lesson”) does not transform violence into non-violence, the harm remains.
- Psychological injury often has greater and more long lasting consequences for people living with violence or the ongoing threat of violence.

#### *Examples of Violence:*

- **Action:** An angry child hits another child with a toy
- **Inaction:** A woman convulses because her husband refuses to release money to pay for her seizure medication
- **Threat:** Stalking a former life-partner with threats of injury or suicide
- **Bullying** (including cyber-bullying): A young person using social media to embarrass or degrade another individual

### Difference Between Violence and Abuse

Violence and abuse are closely related. The distinction lies in the expectation of trust attached to the duties of certain roles. The definition for abuse is the same as that for violence but, in addition, an abuser has failed to carry out the duties and expectations of their role to protect, support, provide care or nurturing. The failure to perform the duties entrusted to this role has introduced risk or the potential for harm.

### **ABUSE**

As outlined in the Child Welfare Act, a child is in need of protective services if there are reasonable and probable grounds to believe that the survival, security or development of the child is endangered because:

- The child has been or there is substantial risk that the child will be physically injured or sexually abused by the guardian of the child

OR

- The guardian of the child is unwilling or unable to protect the child from physical injury or sexual abuse

### ISSUES

The violence we see is only the tip of the iceberg.<sup>2</sup> The impact of violence can extend to entire families, groups and communities. Psychological effects are typically long lasting and often have multi-generational consequences yet much of this remains unrecognized.

The health consequences of violence are matched by vast social, legal and financial implications. Violence is a pervasive health problem that receives far less attention than many uncommon medical disorders. The terrible physical impact of violence is often exceeded by long lasting psychological effects.

The purpose of this guideline is to help physicians understand the mechanisms underlying violence and to increase confidence in the identification and management of health problems associated with violence. Further, the guideline will outline the professional and legal expectations of clinicians and highlight the connections to their moral responsibilities.

### EPIDEMIOLOGY

The estimated prevalence of violence varies greatly in the literature, partly because definitions, methods of ascertainment, and study designs differ so widely.<sup>3</sup> Still, virtually all sources attest to the astonishing magnitude of the problem.

In police-reported data for 2010 there were almost 99,000 victims of family violence in Canada, accounting for one-quarter of all victims of violent crime.<sup>4</sup> Of these family violence victims 49% were spouses and 51% were other types of family members, such as children, parents, siblings or extended family members.<sup>5</sup> The rates of domestic violence in same-gender relationships is roughly the same as domestic violence against heterosexual women (25%). As in opposite-gendered couples, the problem is likely underreported.

Unlike other forms of violent crimes, females had more than double the risk of males of experiencing police-reported family violence (407 female victims per 100,000 population versus 180 male victims per 100,000). This increased risk was primarily attributed to females' higher representation as victims of spousal violence. In 2010, there were over 102,500 victims of intimate partner violence, including spousal and dating violence. This translates into a rate of 363 per 100,000 population aged 15 years and older and was almost 2.5 times higher than the rate recorded for family violence against a child, parent or other family member (150 victims per 100,000).<sup>6</sup>

**Dating violence** was more prevalent than spousal violence, with a rate that was higher than all other relationship categories, including friends and acquaintances. Police-reported rates of intimate partner violence tended to be highest among female victims and among those aged 25 to 34 years. This contrasts with non-intimate partner violence, where the victims were predominantly male and where rates were highest among those aged 15 to 24 years. Based on police-reported data, over half (51%) of victims of intimate partner violence suffered physical injuries requiring medical treatment.<sup>7</sup> On average, every six days a woman in Canada is killed by her intimate partner. In 2011, from the 89 police reported spousal homicides, 76 of the victims (over 85%) were women.<sup>5</sup>

## RECOMMENDATIONS

The clinical role can be summarized by the “three Rs” – **Recognize, Relate** and **Refer**. The key to understanding the clinical role lies in the nuances of the clinical relationship. With this understanding there is potential to enhance patient physician relationships throughout a practice.

### *RECOGNIZE*

Listen and watch for evidence of fear.

The starting point for the physician is creating a practice style that models respectful relationships characterized by a sense of **safety and acceptance**. This style of practice will inspire confidence and mentor healthy relationships that encourage self-directed interactions with teams, resources and communities. A non-judgemental and accepting style will invite and encourage patients to disclose critical information when they are ready. An appreciation of the person's inner strength allows them to move beyond the silence caused by fear, embarrassment and shame and leads to restoration of self-empowerment.

Many brief screening tools and protocols have been developed that assist the clinician in identifying fear in relationships and effectively increase the disclosure rate of violence and abuse.<sup>8,9</sup> One of the easiest to use is the Partner Violence Screen (PVS), a three-item questionnaire<sup>3</sup> that can rapidly and efficiently identify a significant proportion of victims of violence in the physician's practice. The three questions are:

- Do you feel safe in your present relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?
- Have you been hit, kicked, punched or otherwise hurt by someone within the past year?  
(Variants of this question have been included in screening instruments since the mid-1980s.)

Although they pertain to violence from a partner, these questions can be adapted to inquire about personal safety in any setting. The questionnaires all have a central feature of identifying the element of fear in interpersonal relationships. For this reason a general question about fear can be an effective tool to invite disclosures. The clinician can ask, “Does anyone make you feel afraid?” This simple question leaves the patient open to disclosure when they are ready. The answer might be “no” right now but it also invites a disclosure later when the time is right. It indicates your willingness to discuss this matter and your respect for the person’s right to choose to discuss or not. Evidence shows patients want and expect physicians to inquire about their safety but they are often let down in this regard.<sup>3,10</sup> Clinicians also have a duty to consider the children, “Are you afraid for your children?” This question has an important influence on disclosures.

## ***MECHANISMS OF VIOLENCE***

### *Fear*

- Fear is the power tool used to control others.
- Violence is the manifestation of fear that is intended to control another.
- When feeling more powerful, fear is expressed as, “I will make you afraid **of** me and then you will do what I want.”
- When feeling less powerful, the fear behavior becomes, “I will make you afraid **for** me. Pity me (feel sorry for me) and then you will do what I want.”
- Recognizing the use of pity and fear is critical to understanding situations where violence and abuse can emerge.

### *Control*

Controlling individuals prefer the position of having power over others. Their actions maintain a differential of power typically through degradation, isolation and impoverishment. The tenuous position of power is maintained with the constant atmosphere of fear.

When the power position is lost, there is a sudden shift to pity.

- *“If you call the police, I will be taken away from you and the children and sent to jail. Think what I would go through in jail.”*
- *“If you don’t come back to me, I will be so depressed that I will commit suicide. Come back and save me from this horror.”*

Controlling individuals do not like to feel powerless and out of control. So they will rapidly attempt to regain the feeling of control over those around them. People, including clinicians, need to be aware of this when dealing with potentially violent individuals. One can defuse a potentially volatile situation with these individuals by skilfully helping them to re-establish a sense of control in acceptable ways.

Special skill is required when communicating with a controlling individual who senses this loss of control. Telling the individual to calm down may have a paradoxical effect since the individual believes the details of the situation justify their threatening behaviour. The technique of the “Three-As” can help one to get onside with the individual and change the focus from “you against me” to

“you and I” problem solving this difficult situation. The first “A” finds the thread of truth in the conversation. “I **agree** this is a real concern.” The next step **acknowledges** the emotion so the individual feels less pressure to demonstrate their anger. Finally, **assist** the individual’s effort to regain a sense of control by offering a selection of reasonable choices for problem solving. The “Three-As” have shifted the person from an unproductive outburst of anger to making choices that restore control.

### PRACTICE POINT

**When facing a hostile individual-protect yourself with the “Three-As”:**

**Agree** – find a point of agreement (common ground, truth)

**Acknowledge** – “I think most people would find that very upsetting.”

**Assist** – offer options for their choice (options you can accept)

It should be remembered that it is possible for a violent person to change. Make information and resources available and consider motivational interviewing to address the benefits of change.

### THE CYCLE OF VIOLENCE

The cycle of violence (see [Figure 1](#)) is a well described pattern of behavior occurring in controlling relationships. Here an individual gradually ramps up the fear and threats to establish control. There is a violent outburst followed by a honeymoon phase. The honeymoon phase could be a declaration of remorse and promises of love and better times to come. Flowers and gifts demonstrate repentance. The honeymoon ends and soon the ramping up begins the next turn of the cycle but this time the cycle is shorter and reaches a higher level more quickly ending with more severe violence. The honeymoon phase is shorter and less enthusiastic. With each turn of the cycle things get worse.

#### Multi-Generational Cycle of Violence:

The other cycle of violence that is described is a multi-generational cycle of violence. Witnessing violence in the home as a child increases the likelihood of repeating it in subsequent generations. According to Kalmuss<sup>11</sup> in a study of 2000 adults, when neither form of aggression (parent/child or husband/wife) occurred in one’s childhood family, the probability of a husband being physically aggressive is 1%. When parent/child hitting occurred the probability of a husband hitting his wife increased to 3%. With only the experience of husband/wife hitting, the probability of a husband hitting his wife rose to 6% and if both types of childhood aggression occurred the probability doubled to 12%. Similar patterns were observed in women who had lived in families where either type of violence occurred.

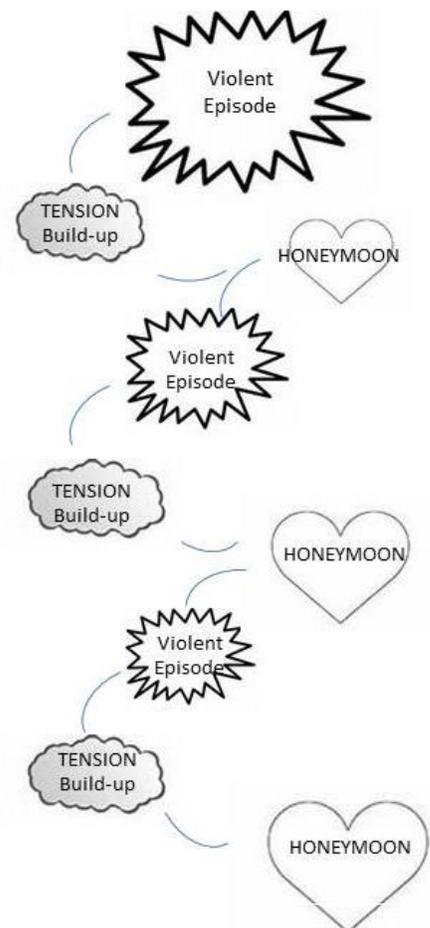


Figure 1:  
Cycle of Violence in Relationships

*Alcohol and Substance Abuse:*

A controlling and potentially violent individual might commit a violent act when disinhibited by alcohol but alcohol itself does not induce violence. Alcohol is neither a cause nor excuse for violence.<sup>6</sup> On the other hand, stimulant drugs of abuse do increase violent behaviors, often with severe violence.<sup>12</sup> Here the drug use is partly explanatory but again does not excuse the violence.

*Stressful Events:*

Stressful events can cause a person to feel their life is out of control. This feeling is particularly undesirable for the individual who is struggling to establish a sense of being in control of those around them. They turn to the behavior they know best. They use fear to control what they believe they can in their life. Often this is the people closest to them. A disagreement becomes an argument with increasing animation and threats of violence used to ensure victory and reassure their sense of being in control. A stressful event is often a trigger for violence but does not excuse the violence.

**RELATE**

In one survey, survivors of domestic violence identified fear of their partner’s retaliation, concerns about mandatory police involvement, and lack of trust in the healthcare provider as important barriers to disclosure and management.<sup>9</sup> On the other hand, they stated that they were more predisposed to seek help when they perceived compassion and interest, awareness, and respect for their need to be in control of the critical decisions. Another study<sup>6</sup> found that battered women valued physicians who did the following:

- Directed their partners to leave the room
- Reassured patients that their feelings of shame, fear, anger and depression were understandable
- Recognized that battering is wrong/illegal
- Provided information about resources

Modelling healthy relationships is the foundation for this area of practice. Clinicians who ask open-ended questions and listen attentively for responses will reinforce their patients’ sense of personal value while nourishing their self-esteem. Respect for each individual can strengthen confidence and foster growth along a path toward self-empowerment. The components of this model of care are outlined in the principles of motivational interviewing (MI). (See Supplement: [Motivational Interviewing with Survivors of Violence](#))<sup>1</sup>

Motivational Interviewing – The Three Key Questions	
1. What are your thoughts about...?	(Readiness to change)
2. How would your life be better if...?	(Benefits of change)
3. Is there anything standing in the way of making this change?	(Barriers to change)

## REFER

- ✓ Offer choices and follow the patient's lead.
- ✓ Provide options for community resources, shelters, experts and programs.
- ✓ Support the adult victim but do not make decisions for them or tell them what they must do.
- ✓ Accept that adult victims must decide when and if they will report to police.
- ✓ Be aware of:
  - The “Public Safety Exemption”: The “promise” of confidentiality might need to be broken when there is real and imminent danger of potentially life-threatening abuse. When a patient has a very high risk of serious violence contact the Canadian Medical Protective Association (CMPA) 1.800.267.6522 and the College of Physicians and Surgeons of Alberta (CPSA) 1.800.320.8624 prior to breaching confidentiality without the adult patient's consent. See [Appendix A](#).
  - Vulnerable individuals: Increased involvement might be needed by clinicians when reduced physical or mental capacity limits an individual's ability to act in self-protection. Again, seek advice from the CPSA and CMPA before violating patient confidentiality. Examples of vulnerable individuals include frail elderly, children and those with developmental delay, physical challenges and minorities.
  - The special reporting responsibilities for child victims have already been outlined. If a child is a witness to domestic violence that also must be reported:
    - Province wide except Calgary: 1.800.638.0715
    - Calgary: 403.297.2995
- ✓ Tap into:
  - Resources in the patient's life and in the community
  - Opportunities for safe shelter and professional referrals
  - Information and contact numbers (written backwards to avoid identification by a perpetrator) exit plans – (the exit kit is stored elsewhere)

### PRACTICE POINTS

#### *How to Help*

**Respect** – patient's inner strength and need to regain control

**Understand** – the things that keep them from moving forward

**Validate** – shame, fear, anger, sadness and losses

**Provide information** – phone numbers written backwards (not identifiable), office posters and pamphlets (open to discussion)

**Inquire** – about the safety of children

**Recognize individual factors** – social, economic, cultural, and religious

**Caution:** When a person attempts to leave a violent relationship, the violence may escalate. Clinicians will need to estimate the level of this risk.

## UNDERLYING PRINCIPLES

- ✓ Ask to understand and engage by inviting discussion.
- ✓ Listen to learn and reflect with respect.
- ✓ Empower by modeling respectful relationships that build on inner strengths.
- ✓ Invite patients to visualize a goal, ‘consider a safe and loving home.’
- ✓ Start with the goal in mind and problem solve to get there.
- ✓ Focus attention on problem solving not people solving.
- ✓ Label the action and behaviours not the person.
- ✓ Acknowledge the patient is the expert on their life, ‘I cannot tell them what to do.’
- ✓ Avoid questions starting with “why”. They invite excuses and rationalization.
- ✓ Reinforce inner control and self-empowerment enable loving and caring for others.

## REFERENCES

1. Toward Optimized Practice (TOP) DOVE Working Group. 2015 January. Motivational interviewing with survivors of violence: a reference guide – supplement to the clinical practice guideline. Edmonton, AB: Toward Optimized Practice. Available from: <http://www.topalbertadoctors.org>
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### ***SUGGESTED CITATION***

Toward Optimized Practice (TOP) DOVE CPG WORKING Group. 2015 January. Doctors opposing violence everywhere (DOVE). Edmonton, AB: Toward Optimized Practice. Available from: <http://www.topalbertadoctors.org>

For more information see [www.topalbertadoctors.org](http://www.topalbertadoctors.org)

### ***GUIDELINE COMMITTEE***

The committee consisted of representatives from psychiatry, family medicine, emergency medicine and social work.

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## APPENDIX A - RESOURCES

### BUILDING SAFETY

- Feeling safe takes time to grow
- Develop internal strengths to increase confidence
- Enhance safety by connecting to people, resources, places
- Ensure privacy for difficult and confidential conversations (shame, embarrassment)
- Personalize to find the right fit – your choices
- Promise only what you know you can deliver!

#### PRACTICE POINT

*Tips for providing resources*

*Phone numbers – write phone numbers backwards for patient*

*Bar codes with number*

*Calendar*

*Lipstick tube*

### PROFESSIONAL AND LEGAL RESPONSIBILITIES

#### CHILDREN

- If abuse is suspected, confirmed or witnessed it must be reported:
  - Province wide except Calgary: 1.800.638.0715
  - Calgary: 403.297.2995
  - For more information contact the Family Violence Information Line: 310.1818

#### ELDERS

- If elder abuse suspected or confirmed contact elder abuse hotline at:
  - Edmonton: 780.454.8888
  - Calgary: 403.705.3250
  - Red Deer: 403.346.6076
  - Lethbridge: 403.394.0306
  - Medicine Hat: 403.529.4798
  - Grande Prairie: 780.539.6255
  - Rural distress line: 1.800.232.7288

## REGARDING ABUSE AND CHILDREN AND WOMEN’S SHELTERS

- Family Violence Info Line: 310.1818 (this number is available for anyone to call)
- Women’s Emergency Shelters
- Child Adolescent Protective Services(CAPS): offers advice to physicians about options available Province-wide (except Calgary) 1.800.638.0715
- Calgary: 403.297.2995
- ZEBRA child protection centre- legal advice/services contact Regional Child Welfare. Children must have a referral through Children’s Services.
- Bullying Help Line: 1.888.456.2323
- Website for children: [www.teamheroes.ca](http://www.teamheroes.ca)
- Child Abuse Hotline: 1.800.387.5437
- Website for youth: [www.b-free.ca](http://www.b-free.ca)
- Website for adults: [www.bullyfreealberta.ca](http://www.bullyfreealberta.ca)

## FOR FURTHER READING

Protection Against Family Violence Act: Can apply for an Emergency Protection Order application – form online: <http://www.albertacourts.ab.ca/forms/cts3755.pdf>

In Protection: Alberta legislation

Cognitively Impaired: Alberta legislation

Legal Aspects:

- Documenting: Alberta legislation
- Reporting: Alberta legislation
- Testifying: Alberta legislation

Books: The Dance of Anger: A Woman’s Guide to Changing the Patterns of Intimate Relationships. Harriet Lerner, Ph.D.

## PHYSICIAN RESOURCES

Physicians dealing with cases such as this may experience vicarious traumatization from hearing these stories and seeing the results of violence and abuse. Furthermore, the stories they hear can resonate with personal experiences now or in the past with additional traumatising effects for the physician. These experiences can be powerful enough to have important psychological consequences. The Physician and Family Support Program (PFSP) (1.877.767.4637) can offer confidential assistance for physicians and their families. For further assistance, the College of Physicians and Surgeons of Alberta (CPSA) can be contacted at 1.800.320.8624.