The Second Kath Dawe Memorial Lecture

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Intimate partner violence and child abuse
Terrorism in everyday lives

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I cannot begin to tell you what an honour it is to be here and to be invited to give this second Kath Dawe Memorial Lecture. Ms Dawe's legacy of innovation in social work practice is truly inspiring to those who knew her and to those who remain influenced by her historic leadership. The work many of you have shared with me is powerful testimony that the work of Kath Dawe is alive and well.

I was privileged to read remarks offered by Professor Dorothy Scott at the inauguration of this symposium and was especially pleased to learn that Ms Dawe had been influenced by a visit in the 1970s to the US where she studied and worked with Dr Henry Kempe and his colleagues who are American legends in the field of child abuse and family violence. I hope she would be pleased that today we are continuing to learn from one another and to exchange our professional knowledge, dilemmas and aspirations for the future. As many of you may know, I have had the very good fortune to work with a number of your colleagues during their visits to Mount Sinai's Department of Social Work Services in NewYork. I want to particularly thank Jane Miller who first talked to me about coming here a year ago but who wrote in a recent email to me '... this is harder than planning a wedding!' I would like to take you back a few months when I began planning for this great adventure.

As I walked to work on a beautiful morning in Manhattan last autumn, I was day dreaming about coming here to Australia. I had just spent a lovely weekend with friends who had returned from Melbourne and I had received an enticing package of travel information from Jane Miller. I was musing about what I would talk to you all about today – how to follow the impressive inaugural talk honouring Kath Dawe. I knew that I wanted to address relationships between intimate partner violence and child abuse and to talk about our professional responses to family violence. However, at 8:46am that sunny, fall day, my thoughts about violence and families were profoundly changed as terrorists attacked our city and crashed two commercial airliners into the World Trade Center. My own peace loving family, untouched in intimate ways by violence, lost beloved friends, watched children become motherless or fatherless, and began from that moment on to experience the shattering and proliferating impacts of incomprehensible and massive violence on families. During these eight sometimes excruciatingly long and sometimes all too brief months, we as a city and indeed as a nation have experienced the powerful resilience of families as they heal. But we have also seen vulnerable families become even more fragile and self-defined as 'victims' rather than survivors. In response to the crisis and its aftermath, our social work profession with our allied health colleagues has responded with extraordinary skill and dedication to help those affected by the tragedy of global terrorism. And we have drawn parallel lessons from this tragedy about how to help those who experience intimate violence or intimate terrorism within their families. Violence in all its forms is catastrophic. Who is resilient and who is vulnerable? Who becomes a victim and who becomes a survivor? How do we social workers help tip the scales in favour of more positive personal and social outcomes?

Who is resilient and who is vulnerable? Who becomes a victim and who becomes a survivor?

The World Trade Center disaster was also a startling illumination of what is important in all of our lives – family, friends, and stable communities. Social workers have relied on our practice wisdom and research knowledge to frame our responses in these troubling times. Identifying patterns of risk, developing programs for prevention and early intervention with those at risk, building social support networks for isolated families and enhancing their emotional reservoirs for coping and adaptation have been hallmarks of social work practice. In the face of violence on any scale, our professional challenge is to help rebuild wounded families – to wrap them in supportive communities so they are not alone in their anguish and so that they have hope for the future; to say to them 'even *this* can be survived' – and the 'this' may be the ravages of substance abuse, crushing poverty, homelessness, racial hatred, chronic and life threatening illness, or violence. While I am going to be addressing my remarks this evening about families and

violence, I hope you will keep in mind the generic and transferable nature of our professional knowledge and skill as we help families every day of our professional lives face a myriad of personal, familial and social wounds.

Family violence is a major contributor to homelessness, juvenile violent crime and substance abuse. It is found among all socioeconomic, ethnic, religious and cultural groups. It knows no geographic boundaries ...

Let me give you an outline of my remarks tonight. I'd like to begin by looking at intimate partner violence and child abuse in their historic and current social and political contexts. I'll digress a bit into the impact of social catastrophes on families at risk. Then I will review the complex, reciprocal relationships between intimate partner violence and child abuse reflected in years of research and practice wisdom. Finally, I want to briefly talk to you about some work being done at Mount Sinai Medical Center to enhance our knowledge of family violence which is in turn helping us to develop new professional practice and education initiatives.

SOCIAL AND POLITICAL CONTEXTS – PAST AND PRESENT

As you know, family violence is a form of abusive behaviour – emotional, physical or sexual – that one person in an intimate relationship uses to intimidate or to control the other. The term 'family violence' is inclusive and encompasses child abuse and adult intimate partner violence, commonly referred to as domestic violence. It takes many different forms and includes behaviours such as threats, name-calling, preventing contact with family or friends, withholding money and resources, actual or threatened physical harm, and sexual assault.

> Victims are pushed, punched, kicked, strangled, and assaulted with various weapons with the *intent* of causing pain, injury and emotional distress (Crowell & Burgess, 1996).

Family violence is a major contributor to homelessness, juvenile violent crime and substance abuse. It is found among all socioeconomic, ethnic, religious and cultural groups. It knows no geographic boundaries and, according to 1995 United Nations Social Statistics and Indicators, is estimated to impact on one in four women in the United States, Canada and Australia and as many as 60% of women in parts of Africa, Latin America and Asia (Enarson, 1999). It occurs in married couples as well as those who are divorced, separated or dating. Most intimate partner violence is committed against women by their current or former male partners. But it also occurs in lesbian and gay relationships. In a small number of cases, men are abused by their female partners, however, international police and court reports consistently show women comprise over 90% of those victimized (Eisenstat & Bancroft, 1999; Tjaden & Thoennes, 2000).

Domestic violence is the most common cause of non-fatal injury to women in the United States, accounting for 22% of the violent crime against women (Rennison & Welchans, 2000). The lifetime risk of severe injury as a result of intimate partner violence has been estimated to be 9% for women, with a lifetime risk of up to 22% for any type of injury (Wilt & Olson, 1996; Kyriacou et al., 1999). In 1996, the Australian Women's Safety Survey found that one in 12 women surveyed had experienced some violence from their current partners, and the rates proved higher when former relationships were taken into account (Indermaur, 2001).

As you know, the medical conditions associated with abuse are numerous. Adult victims of abuse report somatic complaints and use of medical services more often than nonabused women. It is estimated in various US studies that 22%-35% of women presenting in emergency rooms for any reason are there because of symptoms related to ongoing abuse, whether secondary to an injury or as a manifestation of the stress of living under abusive conditions. Between 14% and 28% of women seen in ambulatory medical settings have been abused (Warshaw, 1989; Abbott et al., 1995). Battered women commonly complain of back, chest, and abdominal and pelvic pain. Abused women experience more painful and more frequent headaches; and emotional problems are commonly reported with high levels of anxiety and depression being particularly prevalent (Chambliss, 1997). The victims of physical or sexual abuse have more functional gastrointestinal disorders, report more symptoms of irritable bowel syndrome and are more likely to have had invasive procedures, hospitalizations or surgeries. The risk of *death* from domestic violence is also substantial; about one third of the homicides of women in the United States are committed by a spouse or intimate partner (Rennison & Welchans, 2000).

... the longer a woman stays in an abusive relationship, the more socially isolated she becomes and the more difficult it becomes to secure her safety.

Pregnancy does not protect a woman from violence and, in fact, violence often begins or escalates during pregnancy. The US Center for Disease Control reports that 4-8% of women with live births in the United States have been physically abused during their pregnancies and prenatal battering is the leading cause of birth defects (Petersen et al., 1998). All of these statistics may make your heads swim but I relay them to simply remind us all of how enormous and prevalent a problem violence against women in their homes is. For behind the numbers are real women, many with children, experiencing terrorism in their everyday lives –

unpredictable, explosive and violent outbursts with profoundly enduring consequences. Although often treated separately, violence against women has powerful ramifications for children in these same households.

Even the terms 'domestic' violence or spousal abuse contextualize and relegate the violence into the 'private' sphere, one governed by murky relationships of sexual intimacy and emotion rather than by the rule of law and regulation.

It is important for us to remember that domestic violence is not constant in its expression. Most abuse is ongoing, escalating in both frequency and severity over time – a slow burn in the majority of cases. And when violence occurs, the victim would like to believe that it will never happen again. It is the violence, not necessarily the relationship, that she wants to end. Nonetheless the longer a woman stays in an abusive relationship, the more socially isolated she becomes and the more difficult it becomes to secure her safety. But there are enormous pressures on women to stay. Many are unable to leave because of a lack of financial means, family supports, legal assistance, housing and community resources. Thousands of women are turned away daily from shelters in New York City for lack of space. Some religions pressure women to keep a family together although it may mean tolerating abuse. And there is wide cultural discrepancy regarding the permissibility, and indeed the acceptance, of violence in a spousal relationship. In 18th century British Common Law, the historical basis of our mutual legal systems, laws merely regulated how and when men could beat their wives (with a stick no wider than a man's thumb, not after 8 PM and *never* on Sundays) but they did not prohibit domestic violence. Recent media coverage of violence against women in Afghanistan under Taliban rule is only one extreme example of socially and culturally sanctioned abuse of women in today's world. Although there is widespread social condemnation, domestic violence is still a pervasive public health problem in both of our countries. Several authorities on family violence suggest that in most societies, the significance of violence to women and their children is minimized. Think about it! Even the terms 'domestic' violence or spousal abuse contextualize and relegate the violence into the 'private' sphere, one governed by murky relationships of sexual intimacy and emotion rather than by the rule of law and regulation. Domestic violence becomes framed as individual, aberrant behaviour rather than being recognized as culturally sanctioned, systemic practice. Intimate terrorism! Consider police practices related to family violence in the United States. Calls to our emergency number 911 which are labelled as 'domestics' may be treated as less important or serious than others and law enforcement officers as well as judges may identify a potentially lethal incident as a 'tiff', misunderstanding or lovers' quarrel. However, in a book titled *The Public Nature of Private Violence*, Isabel Marcus reminds us that both critical legal theory and feminist theory underscore the stance that there are no essential qualities which justify this public/private split. A broken arm is a broken arm. She goes on to suggest that violence against women be considered within a human rights framework which transcends the geographic boundaries, histories and practices of any particular nation or state (Marcus, 1994).

Like politically motivated terrorism, intimate violence against women and children is designed to maintain domination and control. If the violence in homes goes unchecked by society, including by our health care institutions, women learn that they can be kept in their culturally and socially designated 'place' by the threat or imposition of physical injury.

Historically, there has been an increased incidence of intimate partner and child abuse following cataclysmic violence such as war and even natural disasters. Sadly, following 9-11 we in New York have been no exception. Dobson's (1994) moving disaster account of a major Australian flood in 1990 was prescient of our experience in New York.

> Human relations were laid bare and the strengths and weaknesses in relationships came more sharply into focus. Thus, socially isolated women became more isolated, domestic violence increased, and the core of relationships with family, friends and spouses were exposed (Dobson, 1994).

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Most people in relationships are pulled together in a tragedy, feeling that family is the most important thing. Abused women feel that same pull. In the aftermath of the World Trade Center attack, many shelters for battered women and children emptied. Women went back to their abusers, precipitated by a feeling that a bad home is better than no home at all. And some abusers had already made terrorism part of their repertoire. 'Come home! This is the time when we need to be together as a family, you need to be here where I can protect you.' These are the seductive words of coercion, which bring women and their children back to violent relationships. But in fact, many of these families face persistent post-disaster problems associated with lost income, unemployment and lost housing and elevations in

perceived powerlessness and frustration. Thus, high-risk women and children face even more danger. As the immediate shock of the disaster has abated, child abuse and domestic violence reports have escalated.

As social workers responded to these families, we have been again confronted with the pervasive and very frustrating conceptual and institutional separation of children's and adults' health and social services. This may be old news to those of you who have worked in the field of family violence over the years, but this dichotomy needs to be squarely faced and seriously modified, if not torn down!

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Thankfully, in recent years, researchers, public policy makers, legal scholars and social workers in practice *have* begun focusing on intimate partner violence and child abuse within the larger context of family violence, reflecting our empirical and most basic understanding that effective child protection is most often provided through ensuring the safety and protection of the child's mother from violence. This does not mean that children are not abused at the hands of their own mothers but rather that the relationship between violence to mothers and their children is often multi-causal and synergistic.

In a recent article in the *Child Abuse Review*, a British journal, the authors argue that domestic violence is a central issue for child protective services. However, they also warn that if domestic violence is seen as yet another new and separate issue to 'take on board', then it will not be surprising if it remains a low priority (Humphreys et al., 2001). In cases of domestic violence, mandated child protection authorities have often been justifiably criticized for focusing on the mother's 'failure to protect' rather than focusing on challenging her partner's violence. Domestic violence can become invisible as the connected or coexisting issue, and the woman re-victimized rather than helped. Many social workers have argued for years that women fail to disclose domestic violence often for fear that they will lose their children to child protection authorities rather than being provided with help that will enable their families to be preserved and that will facilitate their safety. Shortly before I left New York, a federal judge made a landmark ruling which sharply criticized city officials for what he said was a routine practice of removing children from battered mothers by claiming that the mother were 'engaging' in domestic violence. He ruled that the pitiless double abuse of these mothers over years violated their constitutional rights. He went on to state that the practice also harmed children and resulted from benign indifference, bureaucratic inefficiency and outmoded institutional biases. Judge Weinstein's ruling will likely serve as a model for similar rulings throughout the US

In spite of the fact that family violence has generally been dichotomized into adult partner abuse and child abuse, their inter-relationship is striking, with each being a reasonable predictor of the other. Two decades of empirical research provide overwhelming evidence that domestic violence and child abuse are linked within families. The average co-occurrence rate has been estimated to be 40% (McGuigan & Pratt, 2001). Studies have repeatedly identified a history of child abuse, witnessing parental violence or the experience of prior intimate partner violence as variables predictive of subsequent abuse. One study found that 70% of battered women in shelters were abused as children (Stacey & Shupe, 1983), and nearly two-thirds of women with self reported histories of childhood abuse have experienced domestic violence as adults compared to one quarter of women without a history of childhood abuse (Commonwealth Fund Commission of Women's Health, 1998). A variable consistently related to the severity and/or frequency of partner abuse is the adult abuser's own experiences of being abused as a child. Clearly violence is intergenerational behaviour that affects both men and women. Yet many earlier studies relied on the retrospective accounts of victims of violence and were unable to establish a temporal relationship between child abuse and intimate partner violence in a family – the old chicken and egg conundrum. Recent research has demonstrated that intimate partner violence *is* a discrete and significant risk factor for future child abuse in a family. A year 2000 longitudinal study of 2,544 at-risk mothers revealed significant predictive relationships between domestic violence and physical child abuse, psychological child abuse, and child neglect (McGuigan & Pratt, 2000). Children are more vulnerable to being directly physically abused either by becoming caught in the attack upon their mothers or by being abused in separate incidents in which the abuser uses physical assault not only to control his partner but also to control the children in the household.

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Beyond the emotional abuse, beatings and stalkings, abused women live in fear that their partners will hurt their children if they try to leave or to escape, and their fears are justified. Clinical studies indicate that between 40% and 70% of men who batter their partners also abuse their children (Frasier et al., 2001). In 45-59% of reported child abuse cases in the United States, the mother is also being abused. And mirroring their own abuse, a staggering 45-55% of abused

women repeat the cycle and abuse their children. In a year 2000 cohort study, the adjusted relative risk for physical and/or sexual child abuse was twice as great in families with a previous report of intimate partner violence compared with others (Rumm et al., 2000).

Recent studies also confirm the impact of childhood witnessing of intimate partner violence as a discrete variable, which places both males and females at risk for becoming either victims or perpetrators of violence. This data becomes even more troubling when you consider that in the United States approximately four of every ten female victims of intimate partner violence live in households with children under age 12 (Rennison & Welchans, 2000). The majority of these children witness incidents of inter-parental violence.

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Young witnesses are more likely to have behavioural, emotional, cognitive and physical problems than their non-witnessing counterparts. Child and adolescent witnesses show a greater tendency toward acceptance and legitimization of violence with higher levels of aggression, sibling violence and drug or alcohol abuse than children and adolescents who are not exposed to such violence. They have poorer school performance, less empathy for others, and poorer problem solving and conflict resolution skills. Intrapsychic symptoms include anxiety and depression, suicidality, social isolation and withdrawal, trauma and stress reactions, feelings of loss, hopelessness, anger, sadness, and self-blame – many of these reflected on the face of the child on the stair. In fact, many of these children as well as their adult abused parents fit the diagnostic criteria for post traumatic stress syndrome.

As you know, in your country the Women's Safety Survey (Australian Bureau of Statistics, 1996) found that four in 10 women who reported that they were experiencing violence from a *current* partner acknowledged that the violence had been witnessed by children in their care – very similar to US findings. In 1998 and 1999, an investigation about young people's experience with domestic violence was undertaken by the Crime Research Centre at the University of Western Australia and Donovan Research, and represents the largest research project of its kind ever conducted in Australia. Five thousand young people, aged 12 to 20 years old from all States and Territories in Australia, were surveyed. Ten per cent reported being hit for reasons other than bad behaviour. Of these, more than half reported having witnessed adult physical domestic violence occurring concurrently in their households (Indermaur, 2001). Furthermore up to one-quarter of young people reported having witnessed an incident of physical domestic violence against their mother or stepmother.

These studies and others make one thing certain! Far too many children and young people are being exposed to distressing acts of violence by and against one or both of their parents, which can contribute to intergenerational perpetuation of family violence.

In fact, we *know* a great deal about the multiple, reciprocal relationships between intimate partner violence and child abuse. And there is evidence that we are increasingly using that knowledge to assist women and children in real and meaningful ways. In a new documentary film entitled 'Domestic Violence', Frederick Wiseman portrays both the harrowing complexities of family violence as well as some of the heartening examples of where social service organizations can go right. For example, he spends much of the time filming residents of a large family violence shelter called the Spring where abused women and their children receive a vast spectrum of social services, including individual and group therapy, legal counsel, housing assistance, medical care and an on-site public school for their children, the first of its kind in the US. One reviewer of the film wrote, 'After years of abuse and degradation, women's minds have been damaged far more grievously than their bodies' (Mitchell, 2002). Here it is not the system that needs drastic recallibrations but the chaotic lives and thinking patterns of the residents seeking help. And they are getting help!

THE ROLE OF HOSPITALS

In hospitals we are also making strides in fighting this war against intimate terrorism in families. Dedicated health professionals in hospital emergency departments here and in my country capably assess and treat identified child and adult victims of abuse and are most often in compliance with code and regulatory requirements about their care and management. Many have adopted the recommended practice of screening emergency room patients for *actual* violence. But in primary care settings, screening for the presence of family violence in the absence of overt physical symptoms has received a very mixed reception by medical practitioners. Kelsey and Angela Taft reported that only 36.6% of the abused women in their recently published Victoria-based study had disclosed their experiences to their GPs and the vast majority of abused women in the study had never been asked about partner abuse (Hegarty & Taft, 2001). Although women who are abused are frequent consumers of health related services, there is a troubling discrepancy between the large number of women who come to health care settings with symptoms related to living in abusive relationships and the low rate of detection and intervention by medical staff. We treat the symptoms but fail to recognize the abuse. Or do we prefer not to see it?

Even if symptoms are recognizable, the shortcoming of most family violence programs in hospitals is that services are almost always offered after the fact. We *wait* for the explosions before intervening. And remember, it is estimated that only 4% of women sustaining injuries from domestic violence ever present to hospital emergency rooms or to

their physicians for care after an injury. While essential, acute care settings by definition are less than ideal for engaging women and children in planning for longer term, non-crisis driven behaviours to prevent the occurrence or escalation of violence. However, there are surprisingly few research or clinical initiatives focused on family violence risk assessment for the purposes of prevention or risk reduction in primary care settings. If we keep a trauma model as our primary model of intervention, we enable the full scope of family violence to be kept under wraps.

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MOUNT SINAI HOSPITAL DOMESTIC VIOLENCE PREVENTION PROGRAM

In my country, the landmark Violence against Women Act of 1994 called for health care providers to examine risk factors for family violence with the hope of developing early intervention strategies. In response to this challenge, I obtained a grant to establish the Mount Sinai Hospital Domestic Violence Prevention Program – emphasis on prevention. I want to just talk with you briefly about this project whose stated purpose was twofold: to pilot a clinical initiative within primary care medical settings which would attempt to identify women who are *at risk* of domestic violence *before* an incident of actual abuse, and to provide them with education and counselling to prevent the occurrence or escalation of household violence.

We chose two ambulatory care practices for this clinical initiative. The first is a primary care ambulatory medical practice for adults and their children called Medicine-Pediatrics and the second is Obstetrics and Gynecology Associates, the primary care setting for women's health. These practices represented ideal settings and a window of opportunity for inquiry into risks for family violence since women's personal and intimate behaviours are routinely discussed as integral to preventive medical care and management.

A screening questionnaire was developed with 20 items culled from literature on partner violence, published studies, and the clinical experience of social workers at Mount Sinai. The questionnaire was used to screen 431 adult female patients over an 18-month period. Items elicited respondents' *perceptions* of risk in five domains – history of abuse, fear of being harmed, fear of doing harm, high-risk partner behaviours, and depression. High-risk status was defined as having one or more positive responses. A social worker interviewed high-risk respondents to confirm risk and to offer further social work interventions including psycho-education about the dynamics and warning signs of domestic violence escalation, advocacy services including referrals for resources and additional information, and individual or group counselling. Regardless of risk status, respondents were also given an information packet about domestic violence, with user-friendly resource information included. We encouraged low-risk patients to learn the warning signs of intimate partner violence, particularly as related to helping someone in their social network who might be at risk. This practice exposed the low-risk population to information that might have otherwise been inaccessible to them.

After the pilot program had ended, the 431 completed questionnaires were mined for practice-based research purposes. The purpose of the study was to describe the prevalence of risk markers in this population, to determine the correlations among identified risk variables, and to consider implications for early identification and intervention programming.

Although respondents from the Medicine-Pediatrics setting were slightly older than women in the Obstetrics setting, the two populations were comparable on all other demographic parameters other than the obvious difference of pregnancy. Based on our criteria, 47% of respondents in Medicine-Pediatric Associates (n=256) and 48% of those in Obstetrics-Gynecology (n=175) were deemed to be 'at risk' for household violence (See Table 1).

Risk factors were grouped into the five subscales previously mentioned. As shown in the table, in both populations roughly one quarter of the respondents reported having witnessed parental violence and one quarter reported that they had experienced abuse as a child or as an adult or both. Although there is a lesser incidence of reported abusive partner behaviour, the correlational analysis will show it to be a sensitive indicator.

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More dramatically, a large proportion of all respondents, approximately 40%, indicated that they worried about protecting themselves either in their community or households. More specifically, 10% were fearful of their partner and about 13% rated their perceived risk for being abused by that partner as high.

Fear of doing harm was assessed through two items that asked participants about their own perceived capacity to become violent or to lose control with another person. About 30% of respondents worried that their behaviour could

Table 1 : Self-reported history of abuse by clinic

RISK FACTOR	MEDICINE PEDIATRICS (n=256)		OBSTETRICS (n=175)	
HISTORY OF ABUSE				
Witnessed parental abuse as a child	23.7%		25.4%	
Experienced abuse as child and adult	4.4%		7.7%	
Experienced abuse as child	14.8%	26.4%	12.5%	26.7%
Experienced abuse as adult	7.2%		6.5%	
PARTNER BEHAVIOUR				
PREVENTS YOU FROM:				
Seeing friends and family	4.8%		4.7%	
Going where you want	8.2%		11.2%	
Working or attending school	2.8%		3.5%	
Criticizes	11.9%		12.0%	
Shows jealousy	14.6%		17.3%	
Threatens harm	5.6%		6.0%	
PERSONAL FEAR				
Worry about protection at home or in community	40.7%		40.2%	
Frightened or intimidated by partner	9.0%		10.0%	
Rating of risk of abuse	12.1%		14.5%	
FEAR OF DOING HARM				
Can become violent	29.7%		27.6%	
Lose control	22.1%		22.1%	
DEPRESSION				
Sadness	19.8%		21.9%	
Loss of interest or pleasure	39.3%		35.8%	
Sleep difficulty	42.1%		45.3%	
Self esteem	13.0%		13.7%	

become violent while about 22% thought that they could lose control with another person.

In both clinic populations about 40% of respondents experienced a relatively high number of symptoms related to depression, in particular sleep disturbance and loss of pleasure.

Briefly, looking at the correlations among these dimensions, some significant associations were uncovered. There was a strong correlation between having had a history of abuse and fear of being harmed ($r=.463$. $p<.01$ level, 1 tailed) suggesting that the sequalae of abuse are long lasting and pervasive. Prior abuse becomes an organizer of experience – a lens through which subsequent intimate encounters are filtered. Further support of the perceptual process is suggested by the even more powerful association between a history of abuse and a partner's current behaviour. Fear of being harmed was significantly correlated with a fear of doing harm or becoming violent. Finally, depression was to a lesser degree significantly associated with fear of doing harm ($r=.235, p<.01$) and fear of being harmed ($r=.187$, $p<.01$) .

WHAT WE HAVE LEARNED FROM THE RESEARCH

This project, growing out of a clinical program, has offered a conceptual and methodological jumping off point for expanding both future research and clinical initiatives. Its suggestive findings have relevance for both inquiry and practice and have raised more than a few questions. But we have learned a number of things during this exploratory project.

First, we have learned that early risk markers can be identified. Although most women rarely voluntarily or spontaneously disclose information about family violence, when asked, they will tell. In fact, many are relieved to have the opportunity to do so. Health providers may be the only individuals to whom women may safely disclose perceived concerns about family violence.

We also learned that the prevalence of perceived risk for family violence is dramatic in the population of women we are seeing in urban, ambulatory primary care settings. Therefore, a program staffed by one, two, three or even more social workers is just not adequate. In view of the significant health related morbidities associated with family violence, it seems reasonable to suggest that medical providers incorporate family violence risk screening into their general care of all women. Like other behavioural medicine issues, early detection has multiple potential advantages, including making a wider range of behavioural and treatment options available to promote family safety and to prevent more serious adverse physical and emotional consequences for young and adult family members. We have since built upon this project and have received additional funding to create an educational program to equip medical students and resident physicians as well as social workers with the knowledge, skills and attitudes to effectively incorporate early family violence identification and intervention practices in primary care.

As reinforced by our own research and our recent experiences with global and family terrorism, it is clear that adult partner violence and child abuse are not separate issues. They are inextricably interrelated and tied in much more complex ways than our institutional arrangements have acknowledged. It is our responsibility as social workers to conceptually push the envelope by seeking new ways to identify families at risk and to engage them in preventive services. This is only the beginning. There is much to learn and much to do, but we must continue along this path if we hope to secure the future safety of women and children and to break the cycle of terrorism in everyday lives. ♦

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