



Assessment for Lifetime Exposure to Violence as a Pathway to Prevention

Linda Chamberlain

With contributions from Peggy Brown

Exposure to violence is an all too common experience that is associated with long-term health problems, increased risk of revictimization, and intergenerational violence. Many survivors experience multiple victimizations over the lifespan (Dong et al., 2004; Felitti et al., 1998). While exposure to violence is a leading predictor of morbidity and mortality (Arias, 2004; Coker, Smith, Bethea, King, & McKeown, 2000; Felitti et al., 1998; Springer, Sheridan, Kuo, & Carnes, 2003), the health care and public health responses have been inconsistent and fragmented at best. Clinical interventions for exposure to violence are usually limited to screening for current or recent victimization and addressing the immediate health consequences and safety concerns. Most community-based prevention initiatives have not systematically examined how past victimization may impact strategies to prevent future violence.

Assessment for lifetime exposure to violence can identify unknown, unresolved histories of victimization and lead to detection, early intervention, and prevention of predictable health consequences and future violence. Education about the long-term effects of exposure to violence will help service providers and communities to recognize that many of the adverse outcomes associated with victimization are not immediately apparent and that there are ongoing opportunities for prevention. The purpose of this paper is twofold: 1) to provide a brief overview of the research on lifetime exposure to violence and the long-term health consequences, and 2) to examine how assessment for lifetime exposure to

violence can create a pathway to prevention and address the long-term consequences of exposure to violence over the lifespan.

Lifetime Exposure to Violence

The full spectrum of violence over the lifespan is an enormous topic that is beyond the scope of this paper. Lifetime exposure to violence includes bullying, sibling abuse, elder abuse, physical and sexual assault by a family member, acquaintance or stranger, domestic violence (physical, sexual, and emotional abuse by an intimate partner), childhood exposure to domestic violence, media violence, and other unrecognized forms of trauma. While research and prevention initiatives have tended to focus on the physical trauma caused by violence, non-physical forms of interpersonal conflict including intimidation, threats, neglect, deprivation, obstructing personal freedom, and controlling behavior have serious consequences. Violence is not gender-neutral and for most forms of victimization, women are disproportionately affected (Sachs-Ericsson, Plant, Blazer, & Arnow, 2005; Stein & Barrett-Connor, 2005; Tjaden, 2000).

For the purpose of this discussion, lifetime exposure to violence is limited to childhood abuse, childhood exposure to domestic violence, domestic violence, and lifetime physical and sexual abuse. The prevalence and long-term consequences of these forms of victimization have been well documented in numerous retrospective studies and some

prospective studies. It is important to note that the prevalence statistics reported in this paper are likely to be gross under-estimates of the true incidence of abusive events. Estimates of the prevalence of violence also vary due to different case definitions of violence, different types of study populations, and data collection methods. Diverse populations are under-represented in many of the studies on interpersonal violence.

Studies on past exposure to violence typically rely on recall of past events—often referred to as retrospective data. While concerns have been raised about the accuracy and reliability of retrospective data, recent studies indicate that these data are relatively accurate and that the major problem is substantial underreporting of the true incidence (Dube et al., 2004; Hardt & Rutter, 2004).

Magnitude of the Problem

An alarmingly high proportion of adults disclose past histories of childhood physical and sexual abuse. In landmark research on adverse childhood experiences called the ACE Study, nearly 1 out of 4 adults (22%) disclosed childhood sexual abuse and 1 out of 10 (10.8%) said they were physically abused as children (Felitti et al., 1998). More than one-quarter (27%) of women and sixteen percent of men reported a history of sexual abuse in a national telephone survey (Finklehor, Hotaling, Lewis, & Smith, 1990). Millions of children grow up in homes with domestic violence. According to national survey data, approximately one-third of men and women witnessed domestic violence as children (Straus, 1992). In the ACE Study, approximately 1 out of 10 adults witnessed their mother being physically hurt and/or threatened with a weapon (Felitti et al., 1998).

Women are at significantly higher risk of being abused by an intimate partner compared to men (Tjaden, 2000). Findings from the National Violence Against Women Survey (USDOJ, 2000) indicate that the lifetime prevalence of physical and/or sexual abuse by an intimate partner is higher among non-white women (28.6%) than white

women (24.8%). Non-white men (10.0%) are also at higher risk of having ever been victimized by an intimate partner than their white counterparts (7.5%). The prevalence of lifetime physical and sexual abuse ranges from 13% to 59% among women and 5% to 11% among men (Allsworth, Zierler, Krieger, & Harlow, 2001; Stein & Barrett-Connor, 2005; Talley, Fett, Zinsmeister, & Melton III, 1994).

Long-term Adverse Outcomes

A history of childhood victimization is highly correlated with long-term mental health problems including depression, anxiety disorders, posttraumatic stress disorder (PTSD), suicide attempts, sleep problems, sexual dysfunction, and eating disorders (Springer et al., 2003). Survivors of childhood abuse are more likely to experience a wide array of somatic health complaints, as well as fibromyalgia, chronic fatigue syndrome, chronic pain syndromes, and irritable bowel syndrome (Springer et al., 2003). Similar patterns of long-term health effects have been observed in numerous studies on the impact of physical and sexual violence against women (Goodman et al., 1993).

Adults who were abused as children and/or exposed to domestic violence are more likely to struggle with morbid obesity, depression, alcoholism, drug abuse, tobacco use, and suicide attempts (Anda et al., 1999, Dube et al., 2002, Felitti et al., 1998). Similar patterns of health problems have also been reported for adult victims of domestic violence. Both men and women who experienced violence in a relationship are more likely to be diagnosed with depression, substance abuse, and chronic mental illnesses (Coker et al., 2002; Tanskanen et al., 2004).

Exposure to violence over the lifespan is associated with an increased risk of chronic diseases. Adults who were abused as children or witnessed their mother being abused are more likely to be diagnosed with ischemic heart disease, liver disease, cancer, and chronic lung disease (Dong et al., 2004; Felitti et al., 1998; Hillis, Anda, Felitti, Nordenberg,

& Marchbanks, 2000). Women who have been physically or psychologically abused by an intimate partner are at increased risk of being treated for arthritis, migraines, sexually transmitted diseases, stomach ulcers, and spastic colon (Coker et al., 2000).

An often-ignored risk of lifetime exposure to violence is the elevated risk of future violence, a critical consideration for prevention. Past exposure to violence increases the risk of revictimization (Arias, 2004; Elliot et al., 2004; Noll, 2005; Whitfield et al., 2003), the potential of perpetrating violence (Alexander et al., 1991; Lang et al., 2002; Whitfield et al., 2003), and transmitting violence to the next generation (Avery, Hutchinson, & Whitaker, 2002; Cappell & Heiner, 1990; Kalmuss, 1984; Noll, 2005).

Assessment for Lifetime Exposure to Violence

The long-term adverse adult outcomes associated with past victimization make a strong case for addressing lifetime exposure to violence in a wide range of service settings. Health care facilities and public health agencies are an obvious starting point to implement assessment for lifetime exposure, particularly if screening for current or recent victimization is already occurring, and safety protocols and confidentiality procedures are in place. Asking patients about past exposure to violence may also help to establish the trust and comfort level for patients to talk about current victimization and safety concerns.

Questions for lifetime exposure to violence can be integrated into routine health histories and self-administered patient assessment forms. At Kaiser Permanente, a large managed care provider in California where the ACE study is based, more than 58,000 adults have completed the Family Health History questionnaire, which includes a comprehensive assessment of lifetime exposure to violence (Kaiser Permanente, 1998). The Childhood Trauma Questionnaire developed by Bernstein and colleagues is a 28-item self-report screening tool that has been validated with adults and adolescents

(Bernstein & Fink, 1998; Bernstein, Ahluvalia, Pogge, & Handelsman, 1997). Research suggests that survivors want to talk about their past experiences in a supportive, safe environment. In a pilot study to evaluate a computerized screening tool for lifetime exposure to violence, female survivors valued the opportunity to discuss their past experiences with their health care provider (Whiteman, Chamberlain, & Greenwood, 2004). In another study evaluating computer-assisted screening in the emergency room, a number of survivors disclosed past abuse in response to a question asking about current victimization (Rhodes, 2005). Interviews with these patients revealed that they wanted to discuss distant experiences with violence and were not confused about what the questions were asking. Examples of screening questions for exposure to violence from health history questionnaires and screening tools are provided in Table 1.

Table 1. Examples of Screening Questions for Lifetime Exposure to Violence

Screening Questions	Response Options
<p>Sometimes physical blows occur between parents. While you were growing up, that is, in your first 18 years of life, how often did your father (or stepfather) or mother's boyfriend do any of these things to your mother (or stepmother):¹</p> <ol style="list-style-type: none"> 1. Push, grab, slap or throw something at her? 2. Kick, bite, hit her with a fist, or hit her with something hard? 3. Repeatedly hit her over at least a few minutes? 4. Threaten her with a knife or gun, or use a knife or gun to hurt her? 	<p>never once/twice sometimes often very often</p>
<p>Sometimes parents or other adults hurt children. While you were growing up, that is, in your first 18 years of life, how often did a parent, stepparent, or adult living in your home:¹</p> <ol style="list-style-type: none"> 1. Push, grab, slap or throw something at you? 2. Hit you so hard that you had marks or were injured? 	<p>never once/twice sometimes often very often</p>
<p>When you were a child or teenager were you ever hit repeatedly with an implement (such as a belt or stick) or punched, kicked, or burnt by someone in the household?²</p>	<p>Yes/No</p>
<p>When you were a child or teenager did you ever have any unwanted sexual experiences?²</p>	<p>Yes/No</p>
<p>Have you ever been threatened, hit, punched, slapped or injured by a husband, boyfriend, or significant other you had at any point in the past?³</p>	<p>Yes/No</p>
<p>Have you ever been hurt or frightened so badly by a husband, boyfriend, or significant other that you were in fear for your life?³</p>	<p>Yes/No</p>
<p>I have been threatened or abused as an adult by a sexual partner.⁴</p>	<p>Yes/No</p>
<p>Has anyone, during your lifetime, ever made you take part in any sexual activity when you did not want to?⁵</p>	<p>Yes/No</p>

¹Family Health History Questionnaire, Felitti et al, 1998

²Childhood Experience of Care and Abuse Questionnaire (CECA.Q); Smith et al, 2002

³Domestic Violence Screening Tool; Furbee et al, 1998

⁴Southern California Permanente Medical Group Health Appraisal Questionnaire

⁵Assessment Questions for Lifetime IPV & Forced Sex, Whiteman & Chamberlain, 2004

The clinical value of identifying lifetime exposure to violence can be far-reaching. A clinician's discovery that a disproportionate number of morbidly obese patients who dropped out of a highly successful weight loss program disclosed a history of childhood sexual abuse led to an ongoing collaboration between Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) to conduct the ACE study (Felitti, 1991; Felitti et al., 1998). This research demonstrates the need to identify and address past victimization to be able to effectively treat current health issues. Unrecognized, unresolved histories of abuse can sabotage the effectiveness of interventions for health-compromising behaviors such as tobacco use and substance abuse. Understanding the possible connection between past victimization and chronic diseases provides a unique opportunity to identify hidden risk factors and provide more effective case management for patients' physical *and* psychosocial needs. Since many of the consequences of exposure to violence are not immediate and may occur decades after the trauma, there are multiple opportunities for prevention over the lifespan.

Assessment as a Pathway to Prevention

Identifying lifetime exposure to violence creates the opportunity for early intervention and prevention of long-term adverse outcomes. Violence prevention initiatives need to take into consideration how past exposure to violence may impact the effectiveness of strategies to prevent future violence. Expanding our vision for prevention to address lifetime exposure to violence promotes a more comprehensive, coordinated approach that acknowledges the connections between different types of victimization and the similar patterns of long-term consequences.

Prevention Continuum

Traditional prevention theory is based on a hierarchical model of three levels of prevention: primary, secondary, and tertiary prevention. Primary prevention is usually defined as some type of an action to prevent an adverse event from ever

happening, while secondary prevention activities focus on early identification and intervention to reduce the risk of adverse outcomes. Tertiary prevention is responding after the adverse event to reduce the damage. The prevention continuum, a conceptual model that builds upon traditional prevention theory, creates ongoing opportunities to prevent violence and the adverse outcomes of lifetime exposure to violence over the lifespan. The prevention continuum shifts the emphasis from focusing on one level of prevention to identifying and integrating opportunities for different levels of prevention to address violence over the lifespan. The range and magnitude of long-term adverse outcomes associated with lifetime exposure to violence necessitates a broader approach that promotes multi-level prevention strategies.

Survivor-Inclusive

There are two key aspects of how the prevention continuum is "survivor inclusive." First, the prevention continuum recognizes that there are opportunities for all levels of prevention with survivors. Assessment for lifetime exposure provides opportunities not only to address past victimization and the consequences of that exposure (tertiary prevention), but also early identification and intervention for related health-compromising behaviors (secondary prevention). Moving along the prevention continuum for survivors, there are also opportunities for primary prevention of future disease, revictimization, and the intergenerational transmission of violence. For example, educating/counseling survivors about healthy relationships can prevent revictimization. Patient education on how trauma is associated with unhealthy coping behaviors can help survivors to seek intervention and make healthier choices thereby preventing future disease.

The prevention continuum recognizes that significant proportions of any population are survivors due to the high prevalence of lifetime exposure to violence. Without assessment, past exposures are likely to remain hidden. For example, consider a primary prevention initiative on adolescent dating violence. Many teens in the target population will

have prior exposure to violence that increases their vulnerability to violence, their risk of dating violence, and, consequently, their response to the prevention strategy. Without assessment, past exposures are likely to remain hidden.

Prevention-Readiness

Addressing lifetime exposure to violence along a prevention continuum creates the opportunity to build “prevention readiness” into prevention activities. People with prior exposure to violence may have different or additional needs that should be integrated into violence prevention strategies to enhance success. In communities where violence is extremely pervasive due to societal issues such as cultural oppression and economic disparities, promoting prevention-readiness as part of a prevention initiative is essential since a large proportion of the population will have been exposed to violence. Using the prior example of a primary prevention initiative on dating violence, teens abused as children and/or exposed to parental domestic violence may benefit from additional counseling, mentoring, and support groups to help them become more responsive/prevention-ready for the initiative. The important issue here is not trying to fit into the right box or category of prevention, but rather the need for a more comprehensive approach to prevention that acknowledges and addresses the full spectrum of violence over the lifespan.

Providers’ Role in Prevention

The prevention continuum provides multiple points of entry for prevention. Providers who are addressing either the immediate or after-effects of victimization (tertiary level services) also have a role in primary prevention of the long-term consequences of exposure to violence. For example, a primary care provider diagnoses irritable bowel syndrome in a young woman who has been struggling with gastrointestinal problems for some time and has not responded well to standard treatment protocols. The provider screens for lifetime exposure to violence and the patient, for the first time, discloses a history of childhood sexual abuse. The provider is

supportive to the patient and provides patient education on how exposure to violence can impact long-term health. The provider also discusses the increased risk of health-compromising behaviors as coping mechanisms for trauma. The patient discloses that she has been cutting herself, a problem that the provider was unaware of. Referrals for counseling and advocacy are offered to the patient. Information about healthy relationships is also provided to prevent future victimization. The role of the provider spans from tertiary prevention (minimizing the effects of past victimization/existing disease) to secondary prevention (early identification and intervention for other related health consequences) to primary prevention (talking about health relationships to prevent future violence).

Examples of how assessment for lifetime exposure to violence can be a pathway to prevention in different settings are provided in Table 2. The traditional levels of prevention are shown in italics to demonstrate how providers can move along the prevention continuum from addressing the current problem, to detection and intervention for hidden problems and risks associated with past exposure to violence, to preventing future disease and violence.

Conclusion

There is compelling evidence that lifetime exposure to violence is exceedingly common and has serious long-term implications. There are parallel patterns of adverse health outcomes associated with childhood and adult exposure to violence ranging from chronic diseases to health compromising behaviors to future violence. Assessing for lifetime exposure to violence can lead to more effective care for existing health issues, detection of hidden risk behaviors that are highly correlated with past exposure to violence, and prevention of future disease and violence.

The prevention continuum promotes multi-level prevention that begins with survivors and extends to future generations. The prevalence of lifetime exposure and the long-term consequences necessitates a broader approach to violence prevention. The prevention continuum addresses all levels of prevention with survivors and emphasizes the importance of additional prevention strategies to promote prevention-readiness.

While assessment for lifetime exposure to violence can lead to prevention opportunities, it does not address the societal roots of violence. It does, however, increase awareness of the devastating impact of violence on survivors and society and create opportunities to interrupt the cycle of violence and adverse outcomes. Assessment for lifetime exposure to violence may be the next logical step towards universal screening for victimization and perpetration violence.

Efforts to increase awareness of the long-term implications of lifetime exposure to violence and promote multi-level prevention in the health care setting are not risk-free. Providers need training on assessment and trauma-informed practices that are responsive and sensitive to the needs of survivors. Resources for survivors are limited or non-existent in many communities, which ultimately makes the role of health care providers even more important in terms of addressing this leading determinant of health. Increased awareness can lead to increased opportunities to advocate for more resources to

address the long-term effects of exposure to violence. The Family Violence Prevention Fund is developing educational folios on lifetime exposure to violence for health care providers and patients that will be distributed through their website at www.endabuse.org.

While knowledge about the long-term effects of exposure to violence should promote a more compassionate environment for survivors, there is also the risk that information will be used against survivors. Examples include insurance companies denying health insurance to survivors and attorneys minimizing damages in lawsuits and labeling survivors as malingerers based on a history of past exposure to violence. With every action, there is risk of adverse outcomes. Policies will need to be put in place or adapted to protect survivors. The reality is that too much is known about lifetime exposure to violence to continue business as usual and the ramifications extend far beyond the health care setting to other services and programs that frequently serve survivors. Assessment for lifetime exposure to violence in the health care setting is a starting point to develop a community-wide response to violence over the lifespan.

Author of this document:

Linda Chamberlain, Ph.D., M.P.H.
Founding Director
Alaska Family Violence Prevention Project
(907) 235-1922
howlinghusky@gci.net

Consultant:

Peggy Brown, Executive Director
Alaska Network on Domestic Violence &
Sexual Assault
(907) 586-3650
pbrown.andvsa@alaska.com
www.andvsa.org

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In Brief:
**Assessment for Lifetime Exposure to Violence
as a Pathway to Prevention**

Exposure to violence over the lifespan is very common and is associated with long-term health problems, increased risk of revictimization, and intergenerational violence. Assessment for lifetime exposure to violence can identify unknown, unresolved histories of victimization and lead to detection, early intervention, and prevention of predictable health consequences and future violence. This paper examines how assessment for lifetime exposure to violence can create a pathway to prevention and address the long-term consequences of exposure to violence over the lifespan.

For the purpose of this discussion, lifetime exposure is limited to childhood abuse, childhood exposure to domestic violence, domestic violence, and lifetime physical and sexual abuse. Retrospective studies that ask adults to recall past traumatic events have revealed that these forms of victimization are extremely prevalent. A growing body of research has documented similar patterns of chronic diseases, risk behaviors, and other health problems that are highly correlated with these different forms of victimization (Felitti et al, 1998; Goodman et al, 1993; Springer et al, 2003). An often ignored outcome of lifetime exposure to violence is the elevated risk of revictimization, perpetrating violence, and transmitting violence to the next generation (Arias, 2004; Avery et al, 2002; Noll, 2005; Whitefield et al, 2003).

The long-term adverse adult outcomes associated with past victimization make a strong case for addressing lifetime exposure to violence in a wide range of service settings. Assessment for lifetime exposure to violence in the health care setting can be a starting point to develop a community-wide response. Questions for lifetime exposure to violence can be integrated into routine health histories and self-administered patient assessment forms. Research suggests that survivors want to talk about their past experiences in a supportive, safe environment (Rhodes, 2005; Whiteman, Chamberlain & Greenwood, 2004).

Making the connection between past victimization and chronic diseases provides a unique opportunity to identify hidden risk factors and provide more effective case management for patients' physical *and* psychosocial needs. Identifying past victimization also creates opportunities for early intervention and prevention of long-term adverse outcomes. This paper introduces a conceptual model called the prevention continuum that builds upon traditional prevention theory to identify ongoing opportunities for multi-level prevention strategies to address the effects of violence over the lifespan and prevent future violence. This approach creates the opportunity to build "prevention-readiness" into prevention activities by addressing how past victimization can impact the effectiveness of prevention strategies. The prevention continuum is survivor-inclusive, meaning that survivors are included in all levels of prevention (primary, secondary and tertiary). Examples are provided to demonstrate how providers who assess for lifetime exposure to violence have an important role in primary prevention.