JOINING FORCES Joining Families

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FEATURED INTERVIEW

The How and Why of Intimate Partner Violence

An interview with L. Kevin Hamberger and Sadie Larsen

Biography — L. Kevin Hamberger, PhD

Dr. Hamberger is professor of family and community medicine in the Department of Family and Community Medicine, Medical College of Wisconsin, and an affiliate of the MCW Injury Research Center. Since 1982, he has conducted treatment and research programs with domestically violent men and women and developed and evaluated health care provider training programs to deliver violence prevention and intervention services to patients. He was Principal Investigator (PI) on a recently completed CDC-funded project to evaluate the impact of a health systems change model of intervention to prevent and end intimate partner violence in primary care settings.

Biography — Sadie E. Larsen, PhD

Dr. Larsen graduated from the clinical/community psychology program at the University of Illinois at Urbana-Champaign and completed a postdoctoral fellowship in PTSD at the VA Boston Healthcare System. She now works as a psychologist at the Clement J. Zablocki VA Medical Center. She is an Assistant Professor at the Medical College of Wisconsin. Dr. Larsen has a long-standing interest in gender-related violence and recovery from trauma. She has worked with victims of such violence in various capacities, from crisis hotline work to therapy and research. She is currently researching prevention and treatment of PTSD.

Dr. McCarroll: Much of your research has been on clinical samples of intimate partner violence (IPV) victims and perpetrators. Both of you have published on men's and women's experiences of IPV, screening for IPV, IPV treatment, and the relationship of trauma to IPV, particularly as related to treatment. Another approach to understanding IPV is research on community samples. Could you

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In This Issue

In this issue of *Joining Forces Joining Families* we explore developments in intimate partner violence (IPV) research and practice. Our interview is with L. Kevin Hamberger and Sadie E. Larsen on men's and women's experiences of IPV. In a separate article, we highlight more of their research.

Building Bridges to Research describes meta-analysis, a statistical tool used to obtain an estimate of a difference based on several studies. It is frequently used in evidence-based research.

Our neuroscience article describes how child maltreatment increases the risk for later adult disorders, such as depression, through epigenetic mechanisms. Epigenetics is related to the "turning on or turning off" of genes by the life experience of the individual.

The *Website of Interest* describes the US Preventive Services Task Force, a panel of experts in prevention and evidence-based medicine. We provide links to their recommendations for IPV screening, depression screening, and aspirin for the prevention of cardiovascular disease and cancer.

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explain the differences between research performed on clinical versus community samples?

Dr. Hamberger: In research on IPV, a distinction is usually made between community-based sampling versus clinical samples. Clinical samples are a very narrow part of the total population. They consist of people who reach out for help, either on their own or because someone else thought that there was sufficient distress or problems occurring in their lives that they needed to seek help. They are a special part of the general population. Community samples are often convenience samples such as college students, community dwelling people who are recruited for a particular study, or they might be part of a random selection to represent a broad cross section of society.

Community-based samples are often broader and more representative of the community in general than clinical samples. Therefore, research based on such samples is viewed as being more generalizable and one is more able to make inferences that might lead to theory building and theory testing. Clinical samples are fairly narrow and data from those samples does not necessarily generalize to the broader community. The other side of the argument has also been made, that data from broad community samples do not necessarily generalize and apply to clinical samples. So, they may be two separate parts of the whole picture.

Dr. McCarroll: One of the questions you addressed in your recent papers is the age-old question of whether women are as violent as men. You pointed out differences as well as similarities in men's and women's use and experiences of violence (Hamberger & Larsen, 2015; Larsen & Hamberger, 2015). One result was that men's and women's uses of violence are quite different.

Dr. Larsen: It is hard to boil down our two giant papers into a short answer. In those two papers we were dealing exclusively with clinical samples. One of the common findings in community samples is that men and women seem to endorse using violence at pretty similar rates and that is part of what gives rise to the question of whether women are as violent as men. But, mutual abuse is not necessarily mutual. When you examine men's and women's experiences of IPV, you often find that they are quite different and not really mutual. We have found that the result actually depends on how you ask the question. Part of the finding of equal rates of violence might be sort of an artifact of how the question is asked. If you just ask men and women "Have you hit your partner in the last year?" about equal rates of them will say "Yes." But, if you get a little more specific and ask if it was not joking or horseplay, then the rates start to look different and you see that men actually use more violence than women. So, a lot of what we pick up might be not what we would actually think of as violence. We would say that both men and women use violence, but they seem to use it for largely different reasons. There is a statement in the paper to the effect that when violence is used, women get the worst of it. It affects women much more in financial costs, physical injury, fear, and feelings of being controlled.

Dr. Hamberger: Let me just speak more generally to that. What we found in the review of the literature is that women and men in intimate partner relationships use violence. We start with that as a basic conclusion; there is no denying that. We then looked at some of the different parameters of violence such as whether they initiate violence at the same rate or if it is reactive. The studies that have been done seem

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Joining Families

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Batterer treatment is evolving. Many men who batter grew up in violent households and were abused as children. They carry the legacy of trauma with them. People are now starting to think about how to address the trauma issues as part of the overall treatment package.

to suggest that in clinical samples, women tend to use violence more in reaction to their partner's violence whereas men tend to initiate it. That was borne out in some straightforward questions of who uses violence first and in indirect ways by looking at the arrest records of the partners of individuals who are arrested. For example, when women were arrested they found that their male partners had much longer arrest records for prior domestic violence than the women who were arrested and the reverse was also true. When the men were arrested the women partners had shorter prior arrest records than the men, which suggested that women were more reacting to partner violence than initiating it. Other studies of recidivism seem to indicate that even in dual arrested couples that when they followed them for up to five years and followed their police report activity for new domestic violence, women were more likely to show up in subsequent police reports as victims whereas men were more likely to show up as perpetrators.

When we looked at motivation for violence, a fuzzy picture emerged. I published a paper in 2005 in which it seemed pretty clear that women's motivations tended to be more around self-defense and retaliation and men's motivations tended to be more around control (Hamberger, 2005). In our more recent review, we still seemed to see more of that retaliation/reactiveness in women's motivation, but there did not seem to be as much of a gender difference in terms of a motivation of control. That raised some questions about the whole issue of control.

Dr. Larsen: That is one of our other ongoing projects, looking at the concept of control. It is difficult to define and measure. It is talked about a lot, but it is not necessarily measured. There were not many papers that we could include in our review that looked at control mechanisms. We are taking a little more in depth look at that right now. Control has a lot of different aspects such as what actions are taken and how those actions are perceived. Violence may be used by both men and women and yet it may not mean the same thing. That was one of our large, overall findings. Just looking at participation rates does not necessarily get at "What does this violence do or mean to the people involved in it?"

Dr. Hamberger: Injury inflicted is different from injury sustained. This is a complex issue. Based on arrests in single incidents, women are more likely to inflict an injury using a weapon whereas men tend to use hands, feet, or head butt. In injury sustained data, women show more injuries than men, but this is usually based on a longer time frame (e.g., 12 months) than a single incident. Other methodological issues come into play in interpreting injury reports according to whether they are self-reports or based on contacts with the criminal justice system.

We also looked at gender differences in emotional abuse tactics. If you look at an overall score on a questionnaire, men and women score pretty much the same. Again, it looks like gender symmetry, but when we looked at gender differences in items, men tended to make lethal threats or try to control their partner's activities and autonomy or their partner's children whereas women tend to yell and shout.

Dr. McCarroll: You have also conducted research on screening for IPV in medical settings. Your program Health Care Can Change from Within, was a systems-level intervention to determine if clinic procedures of screening and a brief intervention lead to different outcomes for abused women. (Ambuel et al., 2013)

Dr. Hamberger: Two clinics were intervention sites and two were usual care controls. Everyone in the intervention clinics was trained about IPV, but only the family practice residents and physicians and nurses conducted IPV screening. In addition to training the clinic staff, the intervention also consisted of provision of patient education materials for IPV prevention, and the development of clinic policies to facilitate all staff collaborating to identify IPV. The usual-care clinics did not display educational materials and did not have written IPV policies and procedures, did not screen specific groups of patients for IPV, and were not collaborating with local IPV agencies.

Dr. McCarroll: In your results, you showed that the intervention group had increased IPV inquiry, discussion, and disclosure than the usual care group. Both groups adopted more safety behaviors and experienced less violence.

Dr. Hamberger: Ours was a fairly small study, but our results are not inconsistent with what larger studies have found. Screening does not necessarily result in less violence or better quality of health compared to no screening. But, importantly, there is a methodological issue op-

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Intimate Partner Violence and Trauma: Research of L. Kevin Hamberger and Sadie E. Larsen

By James E. McCarroll, PhD, and Joshua C. Morganstein, MD

Hamberger and Larsen's 2015 review papers present (1) the methods of violence (the how), and (2) the motivations (the why).

Drs. Hamberger and Larsen reviewed research published between 2002-2013 on men and women who experienced intimate partner violence (IPV) (Hamberger & Larsen, 2015; Larsen & Hamberger, 2015). Both of these articles focus on gender differences in the perpetration, motivation, and impact of IPV in clinical samples and extend an earlier literature review (Hamberger, 2005). Why only in clinical samples? In general, there have been two approaches to research on IPV: samples of large populations and clinical samples. The authors argue for the use of clinical samples in research for two major reasons. First, they are likely to be of interest to policy makers as well as clinicians since these are the people who are most likely to come in contact with law enforcement, legal, social service, and medical providers. Second, there is substantial morbidity and mortality associated with clinical cases of IPV.

The first review presents: (1) the methods of violence (the *how*), (2) the motivation (the *why*), (3) the context and risk factors (the environmental and situational variables), and (4) the physical and psychological consequences of injury (Hamberger & Larsen, 2015). While there were many specific and sometimes conflicting results of the research, the authors concluded that both men and women are active participants in IPV, but women's physical violence appeared to be more often in response to violence initiated against them. Women were also more highly victimized, more injured, and more fearful of their partners. Men were the predominant perpetrators of sexual abuse. The authors suggested that adopting a gender-sensitive approach in working with clinical populations will be beneficial in understanding the problems, formulating interventions, and developing policies.

The second paper described the costs related to abuse, criminal and legal factors, recidivism, substance abuse, and psychopathology (Larsen & Hamberger, 2015). This paper also extended the earlier literature review (Hamberger, 2005) by focusing on the context, risk factors, and consequences of men's and women's experiences of violence, both as perpetrators and as victims. Overall, this review reported that women incur more costs related to abuse than men, are less likely to be prosecuted, and more likely to be granted a restraining order. However, women as perpetrators have more psychopathology with the exception of antisocial personality disorder. While men and women were equally likely to be arrested for IPV in a given incident (though men make up about 80% of total IPV arrests), men were found to have more extensive criminal histories and had higher recidivism. Gender differences in these factors are complex and generalization can be difficult. For example, findings on substance abuse were conflicting and no conclusion was presented. As was concluded in the earlier paper (Hamberger & Larsen, 2015), this review also found that men and women have different experiences of IPV. Due to the findings that IPV experiences differ by gender, the authors recommended that clinical assessment must be in-depth to understand how IPV functions in the relationship and how it impacts the parties involved. Thus, assessment should be based on client needs with an appreciation of gender differences.

Screening for IPV has been a prominent research subject as well as a policy conundrum. Prompts for screening by family practice residents to inquire about IPV led to a dramatic increase in documented IPV inquiry (Hamberger, Guse, Patel, & Griffin, 2010). While this study did not document violent victimization, it did find increased inquiry rates among primary care physicians.

Recent studies have found that routine screening for IPV did not lead to improved women's health or recurrence of partner violence (Klevans et al., 2012; MacMillan et al., 2009). However, these authors suggested that evaluation of services for women after identification of IPV remains a priority. Dr. Hamberger acknowledges the difficulties in routine screening for IPV: time constraints, lack of protocols and policies, and departmental regulations (Hamberger, Rhodes, & Brown, 2015). Hamberger and his colleagues suggest incorporating IPV screening with a broader system-level model in which both screening and long-term

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Men and women have different experiences of intimate partner violence (IPV). Clinical assessment must understand how IPV functions in the relationship. Assessment is based on client needs with an appreciation of gender differences.

IPV services are needed (Ambuel et al., 2013). This model requires: (1) on-site IPV expertise, (2) saturation training (all staff members in a unit), (3) unit-based policies and procedures supporting the organization's commitment to the issue, (4) collaboration with local advocates and IPV experts, (5) quality improvement strategies and primary prevention within a health care system such as posted signage and pamphlets for patients (Hamberger et al., 2014). This model is directed toward intervention as a part of on-going clinical care to decrease IPV and improve women's health. As of this writing, research supporting this type of intervention was lacking. There will be a need to track harms as well as to identify the most appropriate outcome variables. Among these outcomes could be safety and feelings of support from the care provider as well as reducing health care costs (Hamberger et al., 2014).

The effect of the neighborhood on IPV is a relatively new area of inquiry, but lacks theoretical and conceptual models (Beyer, Wallis, & Hamberger, 2015). This literature review discusses social disorganization theory, the process by which social disadvantage and residential instability disrupt social bonds and limit collective activity to maintain social control increasing the likelihood of deviant behaviors. IPV differs from other types of violence in that it is often hidden from public view and one cannot assume that community members will recognize IPV or respond to it. Social isolation may be a protective measure and social support may be negative in communities that encourage IPV. This article asks many questions that could be the subject of further research and also suggests practice and policy implications of possible community efforts to reduce IPV.

Dr. Larsen's research career includes both IPV and responses to trauma. She participated in a study of medical organizational responses to IPV through the support of community councils, organizations made up of groups and individual community members to address a complex social issue (Allen, Larsen, Javdani, & Lehrner, 2012). The organizational environment plays a powerful and central role in shaping providers' behaviors. Twelve health care organizations participated in this study of the moderating effects of the organizational context on changing the response to IPV. Those providers in organizations that supported screening engaged in screening more frequently (though providers at all organizations tended to personally support screening). The council played a critical role in these health care settings by bringing about screening, providing supports in the form of model policies, and training at the administrative and individual provider levels.

In addition to IPV, Dr. Larsen's research has also focused on a variety of traumatic events. The nature of the stressor in the diagnosis of PTSD has evolved over time. Dr. Larsen examined 22 studies to determine whether posttraumatic stress symptoms (PTSS) differed according to whether the stressors were congruent with the diagnosis (e.g., extreme events that are traditionally viewed as traumatic such as combat and IPV) or not congruent (e.g., events that are traditionally viewed as stressful life events such as sexual harassment, divorce, chronic illness, racial discrimination) (Larsen & Pacella, 2016). She found that PTSS were significantly greater following a congruent trauma, but that there was only a small difference in PTSS between congruent and non-congruent traumas.

A similar study, one on recovery from a stressful or traumatic event, asked 107 women to describe a traumatic event and how it affected them (Larsen & Berenbaum, 2014). One week after the end of the study, women reported significantly lower levels of negative affect. Effects were greatest for those with the highest levels of depression at the time of the interview. They concluded that participation in a trauma or stress-focused event is not harmful and may be beneficial, especially among depressed participants. This was thought to occur because interviews may be more beneficial when they allow for more emotional processing than is likely in surveys. However, she suggested that further research could better determine the differences between the experiences of participating in interviews and surveys. In this same group of participants, she studied the relationship between trauma responses and posttraumatic growth to see if emotion regulation strategies could be helpful in recovery from trauma (Larsen & Berenbaum, 2015). Participants completed questionnaires measuring emotion regulation, meaning making, distress and posttraumatic growth (PTG). Emotional processing had a significant indirect positive effect on PTG through its effect on meaning making. Emotion suppression positively predicted distress, but not PTG. Meaning making negatively predicted distress and positively predicted PTG.

Another study of PTSS was conducted to determine if participating in trauma-focused

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There is concern in Veterans Affairs (VA) about young returning veterans who do not seek care, particularly mental health care, and a need to understand the differences in those who seek care and those who do not.

therapy (prolonged exposure, cognitive processing therapy (CPT), and CPT without a written trauma narrative) would exacerbate symptoms or increase drop out (Larsen, Wiltsey-Stirman, Smith, & Resick, 2016). While a small minority of participants experienced symptom exacerbation (depending on the type of trauma-focused therapy), they experienced clinically significant improvements by the end of therapy. The authors concluded that these treatments are safe and effective even for those who experience temporary symptom increases.

There is concern in Veterans Affairs (VA) about young returning veterans who do not seek care, particularly mental health care, and a need to understand the differences in those who seek care and those who do not (Averill, Eubanks Fleming, Holens, & Larsen, 2015). In this review paper, they report that both groups have high rates of screening positive for PTSD and younger veterans fear stigma related to mental health treatment. They recommended that research needs to study relationship status and expressed concerns about veterans of sexual minority status (lesbian, gay, bisexual, and transgender) as subjects of trauma. Further study of PTSD on these issues will greatly enhance services for veterans.

The research of Drs. Hamberger and Larsen has greatly enriched the understanding of current topics facing victims of trauma, whether related to IPV or are militarily-related.

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BUILDING BRIDGES TO RESEARCH

Meta-Analysis Used to Investigate PTSD Diagnostic Criteria

By James E. McCarroll, PhD, and Joshua C. Morganstein, MD

Meta-analysis is a statistical procedure for obtaining an estimate of a treatment effect based on combining the results from many independent studies.

Meta-analysis in clinical research, is a statistical procedure for obtaining an estimate of a treatment effect based on combining the results from many independent studies. It is part of developing clinical procedures due to its ability to analyze results from multiple and sometimes conflicting studies (Haidich, 2010). As described by Haidich, it is a statistical method for analysis.

Research evidence becomes stronger as in ascending a pyramid. The lowest level is animal and laboratory studies. (Some might say that the single observation or anecdote is the lowest level of eviadence.) However, ascending Haidich's hierarchy, the following levels of strength of evidence are case reports, case-control studies, cohort studies, randomized controlled trials, systematic review, and, at the top, meta-analysis.

When many studies are statistically combined in meta-analysis, significant effects can be found that were previously not detected in individual studies.

Meta-analysis begins with a literature search to identify applicable studies. Studies that are selected have important characteristics such as the avoidance of inclusion or exclusion biases, strong statistical methodology, including outcomes such as odds ratios and mean difference estimation. Haidich concludes that meta-analysis has been extremely useful in developing evidence-based medicine, but it is not foolproof. Some results have been contradicted by later studies and by other meta-analyses and no single study will provide all the answers for understanding risk factors, the response to treatment, or other factors affecting disease.

Many studies have been done to attempt to answer questions about clinical procedures. There may many good studies, but with varying and sometimes conflicting results. They may have different study populations, different methodologies, different measures, and different outcomes. Some studies may not even find a statistically significant effect. However, when many studies are statistically combined in meta-analysis, significant effects can be found that were previously not detected in individual studies. Meta-analysis is a systematic review of research studies whose goal is to produce a single estimate of the procedure under study. As a result of its power, it is part of developing clinical procedures due to its ability to analyze results from multiple and sometimes conflicting studies (Haidich, 2010).

Dr. Larsen used meta-analysis in her review of 22 studies in which two types of traumas were defined for posttraumatic stress symptoms (PTSS), traumas that were DSM-congruent and those that were incongruent (Larsen & Pacella, 2016). A congruent trauma is one that fits the definition for PTSD (American Psychiatric Association, 2013). It is a trauma event that is extreme and involves actual or threatened death or serious injury (e.g., combat) and a negative emotional response such as fear or horror. An incongruent trauma is less restrictive than the DSM criteria for PTSD. Incongruent traumas include events that might better be described as stressors (e.g., divorce). The purpose of her review and meta-analysis was to determine whether PTSS differed in studies of events satisfying the DSM criteria (DSM-congruent) to other studies involving an event that was DSM-incongruent to determine whether PTSS differed in studies using these two different criteria.

As a result of her analysis, she found a small, but statistically significant difference between the congruent and incongruent traumas such that there were higher PTSS symptoms for persons with PTSD-congruent trauma than incongruent trauma. The stressors in PTSD are complex. She suggested that while the DSM criteria for PTSD generally capture events leading to higher levels of PTSS. Her use of meta-analysis allowed her to find significant differences between these two types of responses to traumatic events.

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An interview with L. Kevin Hamberger and Sadie Larsen, *from page 3*

Is the intervention from the research protocol resulting in less violence for both groups or is it the effectiveness of the screening and clinic-based intervention relative to usual care?

erating here that has to be sorted out. Whether they are in the intervention group or in the control condition, if somebody reports new violence the research protocols call for providing a brief intervention right then and there. This might consist of some emotional support, giving them some community resource information and safety information. Essentially what happens is that people in both the intervention condition and in the control condition end up getting an intervention and so the intervention effects are hard to tease out.

Is the intervention from the research protocol resulting in less violence for both groups or is it the effectiveness of the screening and clinic-based intervention relative to usual care? We really cannot say at this point. The research protocol calls for brief intervention in the event of reports of new violence over time for women in both groups. We also think there is at least one other possible and plausible explanation for the failure of the study to show group differences in violence reduction. Participants in both groups were interviewed up to 5 times over the 18-month follow-up, during which time participants were asked about changes in violence, new violence, use of a number of specific safety behaviors, as well as the brief intervention noted previously in the event of report of new violence. We believe that the heavy exposure to questions of safety behaviors constituted an inadvertent, unintentional intervention to which all participants were exposed. This suspicion was supported by responses provided in the post-participation interview. Several women, including some in the usual care group, noted that the repeated questions about safety, as well as questions about violence, led them to to think about their personal life circumstances and to make some changes accordingly.

We addressed this finding by calling for further study of the impact of actual research processes on participants. For example, regular study follow-up with questions about violence may be experienced as a positive intervention by research participants, even those in a control condition. We want to develop different ways to conduct follow-up to reduce the likelihood of confounding the method with the intervention.

Dr. McCarroll: What is your thinking about universal screening? Some have argued against universal screening in favor of case finding (Klevans et al., 2012; MacMillan et al., 2009; Wathen & MacMillan, 2012) .

Dr. Hamberger: I am for universal screening. I do not think that research argues strongly against that. I am not aware of any good, solid research that shows that we can identify specific risk factors that are highly sensitive and appropriately specific to domestic violence and that, if we see those, we are going to get all of the domestic violence. However, I am a fan of case finding as well. It is a combination. It is appropriate during annual visits to ask our patients about intimate partner violence. If in the ongoing care of any given patient certain factors stand out, like depression, anxiety, difficulty sleeping, stress, then it is appropriate to explore that with questions about intimate partner violence. To me, it is a *both and* issue, not an *either or* issue.

Dr. McCarroll: What do you think are the most significant barriers to having a good outcome for abused women?

Dr. Larsen: If there is not training and somewhere to refer people after screening, it makes people reluctant to do the screening. That can be one of the barriers, but as we see more integration, it becomes easier to follow-up on these kind of concerns. This fits with the move toward more integrated health care in which behavioral health is much more a part of the primary care team.

Dr. McCarroll: What should treatment be for perpetrators and victims?

Dr. Hamberger: Treatment of perpetrators is morphing and evolving. Anger management has not been traditionally viewed as an appropriate treatment for batterers. The argument goes that battering is something more than anger. It may be a problem of power and control in which anger is often used as a tool to accomplish that. It is not that a perpetrator is necessarily not in control of their anger. That is the traditional argument against anger management. However, the data show that men who batter tend to have more anger expression problems as well as hostility problems than men who do not batter. Not to address some aspect of anger seems to miss the boat, but it may not be the whole package. We are also becoming increasingly sensitive to the idea that many men who batter were themselves abused as children. They grew up in violent households and they carry the legacy of

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Mutual abuse is not necessarily mutual. Violence may be used by men and women and yet it might not mean the same thing. "What does this violence do or mean to the people involved?"

trauma with them into their adulthood. That has been largely ignored in batterer treatment until very recently. People are now starting to think about how to address the trauma issues as part of their overall treatment package. There are still strong elements of accountability. The person who is violent is responsible, but we need to look at some other aspects of these people's lives and help them deal with some of the pain that they have been carrying with them as well as helping them to stop their violence.

Dr. McCarroll: That makes great sense. Is there anything new or different in victim treatment?

Dr. Larsen: It tends to be pretty variable. You have to meet the person where they are, depending on whether they are wanting to leave the relationship or not. It might involve safety planning, it might involve motivational interviewing, and it might involve trauma-focused treatment, so it depends on the individual situation. There is some thinking about adapting batterer treatments for women and what that should look like, which is not all that clear.

Dr. McCarroll: What should treatment look like for women who are batterers or who find themselves in batterer treatment programs? Should it be the same as men in batterer treatment programs or does there need to be an adaptation of the program for women specifically?

Dr. Larsen: It should look a little bit different although there is a subset of women who probably use violence in similar ways as men do. For some women, traditional batterer treatment might be appropriate and for other women it might not be. For instance, if their violence is mainly in response to violence or defensive violence, treatment might need to look different.

Dr. McCarroll: There is more in the literature now about emotional abuse as something that affects health and well-being.

Dr. Hamberger: We see an interaction between emotional and physical abuse every day in clinical practice. Victims routinely tell me that even though their partner ended his physical violence, his continued emotional abuse is just as, or even more damaging, psychologically, than the physical violence. In relationships where the physical violence has ended, ongoing emotional abuse and violence assumes the function of controlling and stifling the victim's autonomy because the emotional violence always suggests the possibility of renewed physical violence, and also plays on the victim's vulnerabilities. Treatment must address ending both physical and emotional abuse and violence.

McCarroll: Thank you both for your work and your time.

Dr. Larsen: Thank you. It has been a pleasure.

Dr. Hamberger: A lot of fun.

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Screening for Intimate Partner Violence and the Recommendations of the U.S. Preventive Services Task Force

There are screening instruments that can identify current and past abuse or increased risk for abuse as well as interventions such as counseling, home visits, information cards, referrals to community services, and mentoring support.

By James E. McCarroll, PhD

In January 2013, the U.S. Preventive Services Task Force (USPSTF) recommended that clinicians screen women of childbearing age (14-46) for intimate partner violence (IPV) and provide or refer women who screen positive to intervention services (Moyer, 2013). (See Websites of Interest for more information on the USPSTF.) This recommendation was given a B Grade indicating that the Task Force recommends the service.

The task force reported that there are available screening instruments that can identify current and past abuse or increased risk for abuse as well as interventions such as counseling, home visits, information cards, referrals to community services, and mentoring support (Moyer, 2013). Counseling usually provides information on safety and community resources. Home visits, in addition to providing counseling, may include emotional support, education on problem-solving strategies, and parenting support. The Task Force found no direct evidence about harm from screening, although they did note some potential harms: shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and repercussion of false-positive reports.

In addition to clinicians in primary care and specialty clinics, screening can also identify women victims of IPV through screening in other health care setting such as pediatric clinics (Dubowitz, Prescott, Feigelman, Lane, & Kim, 2008). A screening instrument for parents bringing in children less than 6 years old for child health supervision, found that 12% of mothers answered at least one of the screening questions positively. Following a positive screen, a social worker would express empathy, attempt to clarify the situation, and discuss options such as a safety plan, crisis intervention, and information on a hotline and shelter. Risks to the child were assessed as well as the need to report to child protective services.

The Task Force recognized that further research is needed. Among these are further study of post-screening interventions, computerized screening and intervention, legal requirements, underlying medical conditions, and dependence on perpetrators. There was a lack of evidence on screening men for IPV as well as for women over childbearing age.

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Influence of Child Maltreatment on Genes Related to Health Outcomes

By James E. McCarroll, PhD, Joshua C. Morganstein, MD, and Robert J. Ursano, MD

Epigenetics is the study of changes in organisms caused by modification of the expressions of genes rather than changes in the genes themselves.

Since the landmark studies on the effects of adverse childhood experiences (ACEs) on health (Felitti et al., 1998), much more research has been conducted. As this area of research has rapidly developed, studies of epigenetics have looked at mechanisms that might be associated with the development of mental health symptoms and disease outcomes following childhood maltreatment.

What is epigenetics? It is the study of changes in organisms caused by modification of the expressions of genes rather than changes in the genes themselves. Genes are segments of DNA inherited from parents and are the basis of inherited characteristics. Gene expression is the mechanism by which genes interact with the environment and other factors to produce the observable behavioral and biological outcomes characteristic of an individual. (These observable changes are called the phenotype.) Epigenetic mechanisms switch genes on or off (gene expression) through biochemical processes. Epigenetic changes and the outcomes of these changes are complex and influenced by many environmental and biological factors. Environmental factors include stress, brain function, and behavior. Social adversity, particularly through parent-offspring interaction, is thought to alter a wide variety of genes which regulate the stress response.

A study of epigenetic mechanisms of disease risk in maltreated and non-maltreated found that maltreated children may be at higher risk for health problems in later life (Yang et al., 2013). Ninety-six abused or neglected children who had been removed from their parents were compared with 96 demographically matched children. There was an average of 17% differences in epigenetic modifications between the maltreated children and the controls. These genes were associated with a wide variety of biological processes related to diseases, including cancer, were identified. The authors concluded that epigenetic mechanisms in maltreated children may be involved in conferring risk for many adult health problems. Thus, child maltreatment is a preventable risk factor for numerous adult health problems.

There are many limitations to epigenetic research in its current state. Not everyone who has been maltreated is affected and many hypotheses remain to be tested. Regardless of the challenges, among the goals of this research is to improve treatment, particularly for those with ACEs. Further research will help to identify those most at risk, optimal prevention and intervention strategies for maltreated children, and ways to reverse epigenetic changes resulting from early maltreatment.

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Gene expression is the mechanism by which genes interact with the environment and other factors to produce the observable behavioral and biological outcomes characteristic of an individual. (These observable changes are called the phenotype.)

Websites of Interest

Created in 1984, the U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force makes evidence-based recommendations about clinical preventive services such as screenings, counseling, and preventive medications. All recommendations are published on the Task Force's website and some are also published in a peer-reviewed journal. Their website provides extensive documentation of screening tests, interventions, suggestions for practice, resources, research needs and gaps, and references.

The USPSTF assigns one of five letter grades (A, B, C, D, or I) to its recommendations. The grade is accompanied by a definition and suggestions for practice. A and B grades are recommended. C, D, and I are either not recommended or recommended with caveats.

As noted in the article on screening in this issue of *JFJF*, the USPSTF recommended that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services. In January 2016, the Task Force recommended depression screening in adults for the general population and for major depressive disorder in adolescents ages 12–18.

The Task Force currently has recommendations on 96 preventive health services. Grade recommendations are given for each. In many cases, there is more than one recommendations in which services are recommended for one group and not for another. For example, for Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care is recommended for adults, but not for persons under age 18. Some recommendations are classified as Inactive, often because evidence may not be current. The website also includes information about services currently being evaluated by the USPSTF. Much additional information can be found on the webpage such as announcements on new topics, public comments, new staff members, final research plans and final recommendations. This information can inform the clinical practices of healthcare personnel as well as provide general information for healthcare decision-making.

Website References

The Home Page of the USPSTF:
http://www.uspreventiveservicestaskforce.org/

A, B, C, D and I Grade Definitions:
http://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions

All USPSTF Recommendations:
http://www.uspreventiveservicestaskforce.org/BrowseRec/Index

Recommendations for Intimate Partner Violence Screening:
http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

Recommendations for Depression Screening:
http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=depression

Recommendations for Aspirin to Prevent Cardiovascular Disease and Cancer:
http://www.uspreventiveservicestaskforce.org/Announcements/News/Item/final-recommendation-statement-aspirin-use-for-the-primary-prevention-of-cardiovascular-disease-and-colorectal-cancer

Announcements on Topics and Information about the USPSTF:
http://www.uspreventiveservicestaskforce.org/Announcements/News/Index/announcements