Special Issue on Domestic Violence
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-General Herbert E. Wolff, U.S.A. (ret.)

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Kapa

The cloth of old Hawaii was made from the paper mulberry plant or wauke. Intricate and colorful designs were sometimes printed on the soft cloth by use of carved bamboo stamps.
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Norman Goldstien MD

When I asked Florence J. Chinn MD, "retired" internist, medical consultant for the State of Hawaii Department of Social Services and Housing from 1979 to 1987, and very active co-chair of the Hawaii Medical Association’s Committee on Domestic Violence to serve as Guest Editor for this Special Issue, she hesitated for a day before accepting. She did not give the usual "but I'm so busy" (and she is!) replies, but she said:

"People may sympathize, but they can never fully understand the fears the victims experience. People may have fears when they learn of the horrors, but they can never feel the depth of the pain sustained by the victims. People may see the smiles and never realize the emotional scars hidden from view."

Thanks to Florence and her stellar panel of contributing authors, this Special Issue of the Journal will help us to better understand and help those who suffer the physical and psychological pain of Domestic Violence.

Florence J. Chinn MD

Optimum care for victims of domestic violence can only be achieved when physicians have an understanding of the fundamental dynamics of the problem, a working knowledge of the available community resources and the recognition of such victims so that early intervention and referrals may be made to the support and advocacy groups for assistance.

The manuscripts selected for this issue present the various challenges of domestic violence faced by physicians. They include a frank accounting by an emergency department physician of his interest in this problem and how encounters over the years changed his attitude. One of Hawaii’s leading medical authority on the subject of domestic violence has written on some of the reasons why some physicians have not taken a more active role as advocates for victims who are their patients. While the physical traumas are successfully treated, oftentimes, the psychological effects are ignored or go unrecognized. A child and adolescent psychiatrist and medical school professor’s paper addresses the effects on children growing up with violence. Another paper reports on the research

Continued on Next Page
findings on a large group of abused victims long after healing has occurred for the physical trauma. Included is a paper by a highly respected trainer of personnel for support agencies dealing with victims, medical social workers as well as nurses and physicians. Because Hawaii is made up of people of diverse cultures, a newly-developed, culturally-sensitive approach for people of Hawaiian ancestry is included; the first of a series in approach to Hawaii’s multiethnic society.

Also featured are some of the high profile advocacy groups, including a paper by a police officer covering the officer’s experiences and the changes which the Honolulu Police Department has made in recent years. A simplified listing of emergency and support services for the major islands of the State of Hawaii is included.

October is Domestic Violence Awareness Month. Various events are being planned for the different islands to increase education and public awareness. A calendar is included for the candlelight vigils to be held.

Recent services made available, but may not be widely known, include:

- Implementation of Lifeline in which victims, who may be in imminent danger and need to reach the police without delay, may apply through PACT-Family Peace Center at 847-3285 for a free cellular phone prepared for 911.

- On October 1, 1996, a new office under PACT-Family Peace Center will be opened for walk-in counseling, obtaining restraining orders, court advocacy and other services. This will enable victims to receive help without having to go to several different offices for these services.

- Earlier in the year the telephone company announced the availability of an automatic telephone service which reveals callers’ numbers. On the recommendation of advocacy groups, the telephone company will provide on request a blocking of such information at no charge. Thus victims who have had to go into hiding will not be revealing their locations.

- Another recent change makes it possible for victims to page for crisis response workers to meet with them at any location other than in their homes. Previously, only physicians were given the pager number to request a crisis worker to go to the physician’s office to counsel the victims.

- A major camera firm is making available a domestic violence injury documentation kit to health professionals at hospitals and clinics at a substantially reduced price for a limited time. Call 1-800-250-6425 for additional information.

Domestic violence is a complex and sensitive problem. When taking patients’ history during medical encounters, physicians are most likely to be the first to learn of the abuse outside of the victims’ family. By referring the victims to advocacy and support agencies, while providing treatment for the physical and psychological injuries, physicians are providing the victims an opportunity to consider their options and safety planning with trained counselors. Abuse increases in frequency and severity over time. Safety for the victims and their children are of prime concern.

If readers find the contents of this issue to be educational and helpful as a resource guide, then our mission will have been accomplished.

Domestic violence is a crime. Know your State’s laws.
Governor’s Message

Governor Benjamin J. Cayetano
September 1996

I am honored by the Hawaii Medical Journal’s invitation to submit a message to readers of this issue dedicated to the subject of domestic violence—the single greatest cause of injury to women in our society.

This is truly a critical topic that deserves the attention of the medical profession in Hawaii. Physicians, members of our medical community, and others who read this monthly journal are in a unique position to deal with this silent epidemic that constitutes a major public health problem throughout our state and nation.

Last year, my first as Governor, I issued a proclamation declaring October to be Domestic Violence Awareness Month in Hawaii. In signing that proclamation, I was pleased to join with a number of community advocacy groups in focusing on the seriousness and enormity of the problem of domestic violence in our society. Again this year, I intend to proclaim October as a month in which Hawaii’s people will address this social issue that cries out for attention and action.

Doctors play a crucial role in early diagnosis. As a “first line of defense,” they have the skills and experience to recognize signs of abuse, along with the resources to refer victims and their families to appropriate agencies for counseling and follow-up.

I commend the journal’s publisher, the Hawaii Medical Association, for its decision to devote an entire edition to domestic violence. I thank Hawaii’s medical community for its past commitment to curbing violence to women and children, and I encourage all of you to continue your participation in this ongoing prevention campaign.

HMA President’s Message

Carl W. Lehman MD

Violence is one of the most profound, yet preventable health epidemics of our time. Domestic Violence is pervasive. There is no protection in economic status, race or creed. Approximately 2,000,000 women are assaulted by their intimate male partners annually in the United States. Twelve million or 25% of American women will be abused in their lifetime. Twenty-five per cent to nearly half of pregnant women have been physically abused and 22% to 35% of women who present to emergency departments for any reason have been assaulted.

The American Medical Association has recognized this silent epidemic in our society. Dr Robert McAfee, a recent president of the AMA and a friend of many Hawaii physicians was very influential during his tenure in emphasizing the importance of this silent epidemic. The Alliance of the American Medical Association has worked to promote good health for all Americans. Many state societies have become active in educating the public and physicians about the significance of domestic violence. The national as well as many state alliance organizations have promoted the SAVE Program (to Stop America’s Violence Everywhere). The American Medical Association has published excellent pamphlets which are available through the AMA which include Diagnostic and Treatment Guidelines on: (1) child physical abuse and neglect; (2) child sexual abuse; (3) domestic violence; (4) mental health effects on family violence; (5) elderly abuse and neglect and (6) strategies for the treatment and prevention of sexual assault.

The American Medical Association’s resident physician section has recognized this silent epidemic and is attempting to educate their colleagues about the problem. Dr Erin Tracy wrote in the JAMA, June 12, 1996, Vol. 275, No. 22 in the resident’s forum about his experience in questioning 8 consecutive patients who arrived at a clinic with routine gynecological complaints. He asked each of them if they had ever been physically abused and was horrified to learn that all 8 women had been physically assaulted by their intimate partners within the past year. He points out that physicians do not routinely ask patients if they have ever been threatened or harmed. As he noted, when women were asked, they showed no hesitation in talking about their experience, but seemed hesitant to volunteer the information.

Why don’t we ask? Is it because we are not prepared to assist the patient who has a problem or are we unprepared to help or refer patients with problems due to domestic violence? Or is it because we have not been trained and feel uneasy in uncovering a problem we cannot handle? These are some of the reasons, although there are many more. Of 143 accredited medical schools in the United States and Canada, only 47% require formal training in domestic violence. The Hawaii Medical Association Committee on Domestic Violence and the Hawaii Medical Association Alliance have been promoting education of physicians as well as the public regarding this problem.

Thanks to all of those members involved in communicating on this subject. If we are to resolve this massive problem of violence, we must teach our children to interact and resolve problems respecting others rights and privileges. We must realize that intimate relations and satisfactory relationships do not occur by one controlling the other, but rather by resolving problems through mutual respect and a willingness to understand each other.

I urge all physicians to include a question regarding physical abuse in initial patient questionnaires or during history taking. When you identify a patient who needs help, please use information in this journal as a source for referral to a crisis agency when you feel you cannot handle the case appropriately.

My thanks goes to Dr Florence Chinn for her hard work and dedication in compiling and organizing the material in this issue of the Hawaii Medical Journal. I also wish to thank Dr Chinn and Dr Shay Bintliff for their leadership and accomplishments as co-chairs of the HMA Domestic Violence Committee through the year.
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I could comment for hours about victims I’ve seen over my 25 years in the Emergency Room (ER) who were battered by those they trusted, about swollen, pulpy, fractured faces; about broken limbs, multiple bruises, stab wounds and gunshot wounds that were meant to maim; about panic, fear, hopelessness and about the deaths of some of the victims. I could comment about the horrific effects on children who witness domestic violence.

Instead, I want to make the same confession I made publicly at a recent conference on domestic violence in Hilo. I am ashamed to admit for the first 7 or 8 years of my ER career, I was one of the health care providers who were ignorant of the dynamics of domestic violence. I, along with many others in the ER, police, rescue teams, victims’ families, etc., felt that battered women “asked for” this treatment. That this was their fault for not just leaving the relationship. “Guess who the medics are bringing in again?” “Hawaiian love,” “What fools those women are,” etc. Some ER staff to this day, feel that way. Something happened to me in the late 70s that changed my outlook. I asked a big violent man why he had beaten his wife, who was a frail, retarded, Japanese woman. His reply was to savagely attempt to attack me to show me “what a real beating was.” In that instant, I realized what horrible terror these victims must feel on a daily basis.

So now, 20 years later, many of us have changed our misguided attitudes, and there is a push across our state and nation to deal with the issue of violence in our society. Dedicated people like the members of the Hawaii Medical Association Domestic Violence Committee, Dr Bob McCaffee and Dr Lonnie Bristow of the American Medical Association (AMA), our HMA staff, judges, prosecutors, police, paramedics and most importantly, victim advocates, have come together to attempt to solve the domestic violence problem. We have immensely dedicated people, many themselves former victims, who run the support groups, shelters and the advocacy agencies that are so critical to the survival, emotionally and physically, of victims.

So why, with the tremendous re-tooling of thinking and multidisciplinary efforts to deal with domestic violence, is this such a gut wrenching issue for me? The answer is simple: Domestic violence continues to rear its ugly head on a daily basis. This past weekend (mid-May, 1996) in the Hilo ER, within three hours I cared for two young women who had been so savagely beaten by partners, that bones were broken. One had been a victim multiple times, and had a long-standing temporary restraining order (TRO) in place against the batterer. Both were asked the question by ER staff and police that Mr Casey Gwinn, the prosecutor for the city of San Diego, says should never be asked: “Do you want to press charges?” Mr Gwinn says, “You don’t ask bank employees after a holdup if they want to press charges.” I’m going to free associate and express a number of thoughts, quotes, ideas and questions about this issue.

I have had the privilege of attending, with my wife Diane, two very powerful conferences recently in Hilo. Both were at New Hope Church and sponsored in part by the Transition Network of Hilo and the Hawaii County Medical Society Alliance (HCMSA). The first meeting involved Mr. Casey Gwinn of San Diego along with a number of local experts. On May 24th, Ms. Denise Brown, the sister of Nicole Brown Simpson, was the keynote speaker at a conference that included a welcome by County Council chair Keiko Bonk-Abramson; Gail Pincus, domestic violence expert from Los Angeles; Alana Bowman, a Los Angeles city attorney and expert on the subject; and Stephanie Launui, Executive Director of the Bay clinic on the Big Island. There was not a dry eye in the meeting hall when Judith Fox-Goldstein of Hilo presented a moving and courageous dedication to her murdered son. On display in the room were photos and memorial displays of murdered victims of domestic violence. Diane had known personally one of the victims and her family, Lynn Kotis, from Honolulu, and I knew Steven Nagao and his family from Hilo. Both had been murdered by partners. At the opening of the session, all the victims of domestic violence were asked to stand. A huge majority of those in the room stood, including most of the speakers and Diane who had been in a brief abusive relationship many years ago. I mention all of this to emphasize how pervasive this problem is in our society and how it affects us all.

The Big Island has some particularly troublesome statistics. Hawaii County leads the state in unemployment and poverty, in the rate of abuse of alcohol and other drugs and in the rate of cases of abuse of dependent adults and children. The Big Island has nearly three times Oahu’s rate of temporary restraining orders (TROs) against perpetrators of domestic violence. More than one domestic violence complaint per day is filed on the Big Island, and I’m sure many other incidents are never reported.

The HMA has sent a resolution to the upcoming AMA House of Delegates meeting asking:
1) that the AMA work in conjunction with victim advocacy groups to evaluate the safety and effectiveness of policies such as mandatory reporting and
2) the AMA evaluate the desirability of uniform national standards for the prosecution of domestic violence cases.

We are all aware of the controversy mandatory reporting creates and of the need for a secure safety net for victims. Casey Gwinn points out that this issue should not be about a dispute between two adults, but about the state or other jurisdiction arresting and prosecuting perpetrators of the crime of battering. At the May 24th meeting, even Gail Pincus and Alana Bowman took opposing positions on mandatory reporting to police. It seemed that a majority of victims were in favor of mandatory health care provider reporting as long as there was a safe place for them to go.

Another area of controversy regarding violence is how much of an association there is between domestic violence and the use and abuse of alcohol and other drugs. I have been at many meetings over
the years and have heard many victim advocates claim, quite
correctly, that substance abuse is no excuse for domestic abuse.
They also state, quite correctly, that substance abuse does not cause
domestic violence. I do not disagree with these concepts, but I
almost never see an injured victim of domestic violence that doesn’t
involve the use of alcohol and/or other drugs at the time of the
battering. My feeling from the recent meetings is that most of the
victims of violence agree with this. I know that ER visits are only
part of the spectrum of domestic abuse.

Alcohol and other drugs don’t cause domestic battering, but usage
escalates the level of violence. The use of ice and crack cocaine
creates an increase in the severity of injuries, and the feeling of the
experts from LA is that it increases the number of murdered victims.
My point in mentioning this is that to stem domestic violence, we
not only need to vigorously prosecute batterers while keeping
victims safe, but we must also vigorously address treatment issues
for batterers. Batterers’ treatment programs will not “cure” batterers
unless they are willing to change their behavior. I don’t know
whether mandatory substance abuse programs will do any good.
Probably not, as it goes against the grain of the “desire for change”
concept of 12 step programs.

I think it is very important, however, to not forget the correlation
between substance abuse and domestic violence. It is not the cause
or an excuse, but there is a definite association. Treatment programs
for batterers must not only address the “power and control” issues,
but substance abuse as well.

Some final thoughts:

- Across America, many courageous people provide shelter and
  comfort to abused women and their children who are literally
  “running for their lives.”—Denise Brown.
- Protection orders against perpetrators of domes-
  tic violence should be enforced across
  state lines. (Guest Editor’s note: The Violence Against Women’s
  Act (VAWA) of 1994 makes this enforcement effective across all state
  courts and tribal courts when a form is filed.)
- “It’s difficult to be brave when you’re scared,
  hard to see light at the end of the tunnel
  with your eyes swollen shut.” —Denise Brown.
- Battered women are at greatest risk when they leave the relationship.
- Batterers are most afraid of jail because they lose the ability to exert power and control. —
  Gail Pincus.
- Everywhere batterers go, the message should be loud and clear: “There is no excuse for
  abuse; domestic violence is intolerable.”
- In some areas, murders in domestic violence cases have declined by one third. Alana Bow-
  man said that some attribute this to mandatory arrest policies. Other experts feel it may
  be a change in drug use from crack to Heroin.
- There are more serious injuries when the batterer uses crack or ice. Alcohol and other
  drugs don’t cause battering, but can contrib-
  ute to more devastating injuries.
- The Big Island needs to have an established
domestic violence response team, like there
is in LA, Honolulu and Maui. LA has volun-
  teers to assist and to respond to incidents with
  police. (Guest Editor’s note: HNL has DART trained personnel that
go with police).
- We must begin teaching about all aspects of
  violence in school curricula. America must

- I’m beginning to see larger numbers of battered teenage girls. It’s
  almost like a fad. A young 16-year-old victim recently excused
  her boyfriend by telling me “He has a lot of stress.”
- “Batterers should start hiding, not the woman they harm” from an
  announcement on new laws in Michigan that will be the toughest
domestic violence laws in the nation.
- A line from the theme song of a factual movie about teen domestic
  violence: “Who would ever guess what lies beneath the tender-
  ness?”
- Hawaii must change its laws to allow for easier prosecution of
  batterers when the victim refuses to “press charges” or testify in
  court. The victim must not be made to be “investigator and
  prosecutor” and must not be blamed for refusing to testify against
  her partner.
- “Our goal should be to allow abused women to not crawl, but
  walk out of a violent relationship, to survive and thrive.”—
  Stephanie Launu.
- A goal should be to “make violence personal and keep victims
  safe.” Bobbie Leone, Executive Director, Transition Network, Inc.
- “Where there is violence, let each of us make a move toward
  gentleness.”—St Francis of Assisi
- “Pity and compassion in a world of pain, mean little unless it leads
  to change.”—12-year-old girl from South Central Los Angeles.
Domestic Violence...Myths and Barriers

Shay Bintliff MD, FACEP, FAAP

The past 15 to 20 years have seen the birth of a new national awareness of the impact of family violence on our national health and resources. The Surgeon General of the United States has identified domestic violence as the nation's number one health problem. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has mandated, as of January 1992, that all emergency departments and ambulatory care facilities establish guidelines for the identification, evaluation, management and referral of adult victims of domestic violence. In June 1992, the AMA published guidelines for identification and intervention with domestic violence victims. All states now have provisions in their laws that define marital rape as a crime, and many states have mandatory arrest statutes for men found by the police to be abusing their wives.

This review identifies some common societal and professional barriers limiting the emergency response to domestic violence.

Myths

A substantial obstacle to intervention is the abundant social and cultural biases which pervade medicine and society as a whole. Left unchecked, they can easily cloud the judgment of physicians evaluating victims of domestic violence. Some common myths are refuted below.

Myth: Intimate abuse is isolated and infrequent.
Fact: The problem is currently recognized as being of epidemic proportions.

Myth: Only poor and minority men beat their wives.
Fact: Domestic violence shows no greater affinity for the lower socioeconomic groups or minorities. The difference appears to have more to do with reporting and the accessibility to resources. Women of greater means tend to have more options available to them for dealing with the problem. Women without such resources are more likely to turn to public agencies for help.

Myth: Just as many wives batter their husbands as men batter their wives.
Fact: In fact, 95 to 99% of domestic violence victims are women. Although not exclusively female, the overwhelming majority of battering victims are women.

Myth: Abuse victims exaggerate their injuries.
Fact: Most battered women minimize their injuries. They are usually not candid about the source of the injuries due to their shame and embarrassment.

Myth: Battered women provoke their abuse.
Fact: Abusers often claim they were provoked in order to avoid accepting responsibility for their actions. This enables them to see themselves as victims and continue their behavior. Additionally, some women, aware of their abuser’s cycle of violence, may provoke an argument in order to diffuse the building tension and stave off even worse abuse they may feel is yet to come.

Myth: Drinking causes battering.
Fact: Alcohol is involved with battering about 50% of the time but is not the cause. Studies have shown that a third of abusers are abusive only when they drink, a third are abusive—drunk or not, and a third don’t drink. Drinking is not a cause of battering but an excuse that abusers use to deny the abuse is a problem.

Myth: Only sick or psychopathic men beat their wives.
Fact: About 20% of men who batter are violent with others as well as their family. The other 80% are not. They are often well-liked and appear attentive with their mates publicly. Since they may be seen as the “perfect husband” by others, the women’s stress over escaping the relationship is heightened. Victims are afraid no one will believe them. Unfortunately, they’re often right!

Myth: If a woman wanted to stop her husband from beating her, she would act differently.
Fact: Battered women usually find that regardless of their behavior with their partners, the battering continues and usually escalates. This illustrates a major pitfall of “blaming the victim.” It is easier to believe that the woman has somehow incited her own abuse. Otherwise, if domestic violence is a random event totally out of the victims’ control, what’s to keep us or those close to us from becoming victims as well? This myth is difficult to erase. Nevertheless, refuting it is crucial to breaking through the barriers to provide appropriate intervention for these women.

Myth: If things were really that bad, the woman wouldn’t stay; therefore, she must like it.
Fact: Many women do leave abusive situations. Women’s shelters are always filled to capacity. Those who stay do so for a variety of reasons. She may think he’ll change or that she loves him enough to “make it work.” She may be afraid of not being able to support herself and her children without a job or the skills to get one. She may think once he realizes what he’s doing, he’ll stop. She may be afraid of retribution with her, the children or other family members and friends. She may not want to break up the family. Her attempts to seek help from the police, courts, clergy, family, friends, etc. are often met with denial and/or disbelief. She may be severely isolated from friends and family (contacts who could help her). Most importantly, she believes him when he says he won’t do it again.  

Myth: Domestic violence does not affect children.
Fact: It is clear from all reviews of statistics that this is not the case.

Myth: If you are pregnant, you are safe from abuse.
Fact: It is not uncommon for the first incident of abuse to occur during pregnancy. Women who are abused also frequently notice escalation of abuse during pregnancy.
Barriers to Physician Intervention
Lack of knowledge and Education

Physicians aren’t trained to recognize the subtleties inherent in the history and physical examination of victims of domestic violence. This difficulty is partly due to the limitations of the “medical model.” It teaches us to break every problem down into the most basic and definable physical entity. Thus, the diagnosis becomes: periorbital contusion, colles fracture, multiple contusions, non-specific abdominal pain, closed head injury or laceration etc., rather than addressing the larger issue of assault—whether domestic or otherwise. The history becomes ahistorical and decontextualized. Therefore, the chart may state “blunt trauma to head, indoors” rather than “head slammed against wall by husband at home.”

Victims may have multiple visits to the Emergency Department (ED), often for nonspecific complaints with the occasional smattering of “real” illness/injury. Rather than recognizing this pattern as symptomatic of domestic violence, physicians may label these patients as “neurotic”, “hypochondriacal”, “hysterical” or “crock”. In this way, the victim’s feelings of powerlessness and low self-esteem are reinforced. Proper training regarding these patterns of presentation can help to overcome this barrier.

Limited resources
Although improving, the availability of medical and community, resources remains inadequate. Those community and hospital resources which do exist are frequently operating at maximum capacity. More shelters, safe houses, social services, drug and alcohol treatment centers and rehabilitation facilities, legal assistance and support groups are needed. The relative lack of those resources is a major source of frustration for those emergency physicians engaged in attempting to impact on this issue.

Societal Misconceptions and Cultural/Personal Biases
Individual experiences and upbringing necessarily affect a physician’s management of domestic violence. The nature of the issue makes it difficult to remain impartial and objective. With little training regarding proper management, we fall back on personal experience for direction. A number of commonly held myths and misconceptions have already been discussed. Additionally, there is the temptation to view domestic violence as a private matter that is best resolved privately—especially in the context of little or no physical injury. In fact, without intervention the vast majority of domestic violence escalates to pose a much greater threat to victims.

Another source of frustration for physicians is the frequency with which violence is repeated. Patients are advised to leave the violent situation and are provided with phone numbers of community outreach organizations. Yet they continue to return to the same environment. This may be incorrectly interpreted as the patient’s lack of concern for her own welfare. In fact, returning to the environment may have a great deal to do with concern for her welfare and that of others with whom she is close. Physicians can provide resources and offer support. We cannot force others to accept our solutions to their problems. Intervention may be undertaken at a later date when further action is more feasible for the patient. Although victims may be unable or unwilling to accept help on one visit, it does not necessarily follow that the response will be the same on the next.

Too close for comfort
Depending upon the age, sex and circumstances of the victim, physicians may identify with them. Those physicians who have not experienced violence in their own lives may have difficulty acknowledging that others who seem much like themselves could have such problems. They may also identify with their abused patients on the basis of their own history of abuse. As an example: One study showed that 14% of all male MDs and 31% of all female MDs have experienced significant familial violence. This may make intervention with victims of violence “too close for comfort” causing some emergency physicians to avoid the issue altogether.

Fear of Offending
Fear of offending the victim is common but rarely occurs. Most victims will welcome the opportunity to discuss the problem. Regardless of whether they disclose their situation, a message of concern was still provided. This identifies the physician and his/her institution as a potential future resource.

Physicians concerned with offending abusers may view the revelation of violence as an accusation needing to be either proven or refuted—neither of which is the role of either physician or patient. It is possible to provide support, information and referral to patients reporting abuse without ever needing to “prove” their credibility.

Powerlessness
All physicians like quick fixes. Unfortunately, intervening with domestic violence will not be one. Lack of training fuels feelings of inadequacy to manage the problem ourselves, and it may appear easier to avoid the issue altogether. Nevertheless, although we can’t “fix” the problem, we are often the first contact for victims. We have the ability to acknowledge the problem and make appropriate referrals. It is important to begin to accept and acknowledge that simple goal as an important beginning for many patients. Physicians must be able to tolerate the repeated events of violence and not give up on their patients.

Time Constraints
This is a powerful concern. How do we deal with involved psychosocial issues with a busy office or an entire department of sick and injured people waiting? Although adept in identifying and managing child abuse victims, we have not, as yet, sufficiently applied those skills to the identification and management of abused women. Although time and resources are often limited, child abuse is not ignored. Rather, available resources are accessed and used to the patient’s best advantage. Fortunately, systems exist for victims of child abuse. It is time to extrapolate that concept to include all victims of domestic violence. Asking direct questions while being knowledgeable of available support systems can ultimately reduce the time required to effectively intervene.

Pandora’s Box
By inquiring about potential violence, physicians fear getting “more than we bargained for”. The problem of limited resources factors heavily here. However, once the problem has been identified, the other physical concerns and usual complaints attain sudden clarity. The problem can now be addressed rather than puzzling over the question. Domestic abuse victims are three times more likely to suffer repeated violence than victims of other violent crimes. Identifying victims may, in fact, decrease the number of subsequent visits because the core issue is being addressed.

Conclusion
Domestic violence is not just a medical or social issue. It is not only a police, trauma of women’s issue, nor a children’s issue or an issue of the elderly. Domestic violence is a pervasive and insidious problem that affects every level of our society.

Our actions may have enormous impact upon the direction this
society takes in the future. We live in the most violent peacetime society in the industrialized world. The sad truth is beginning to unfold that the overwhelming majority of this violent and destructive behavior is learned in our homes. What can be learned can be un-learned. There has been a profound change in the public response to domestic violence over the last fifteen years. However, personal biases, gender stereotypes and societal misconceptions still legitimize control of one partner over the other and therefore rationalize abuse. Let’s seize the opportunity to improve the outcome for these patients while optimizing the proper and efficient use of our limited medical resources. The task may appear daunting. However, considering the potential for improved patient care and outcome, it’s well worth the effort.

References
When Children Witness Domestic Violence

Alayne Yates MD, Professor and Director, Division of Child and Adolescent Psychiatry, University of Hawaii

Children who grow up in violent homes do not necessarily become violent parents later on. Some children remain asymptomatic. However, the majority are behaviorally disordered and others suffer from PTSD, grief reactions and separation anxiety. Children who themselves are not abused are not likely to be identified and appropriately treated.

Historical
Violence against wife and child was legal in this country and in England until the early part of this century. Under the doctrine of patria potestas, family members were the property of the father, and he had every right to discipline them in most any manner he saw fit. However, some limits were recognized: the Rule of Thumb law permitted a husband to beat his wife with a stick no larger than the circumference of his thumb. In some towns husbands were prohibited from beating their wives after 10 pm or on Sunday.1

Incidence
Recent studies2,3 indicate that at least one in five women patients in a primary care setting have experienced domestic violence in their adult life and at least 1 in 20 have experienced it in the past year. Yet these patients rarely report being abused to their physicians. Women who are subject to abuse are likely to be under age 35 and separated or divorced. As a group, they have many problems including suicide attempts, drug abuse, anxiety, depression, and somatic concerns but they are not more likely to be hospitalized for psychiatric treatment. Less is known about the (usually male) abusers or the kinds of interpersonal issues that foster family violence. However, the level of violence can be predicted by the amount of couples’ conflict about child-rearing and the social support available to the men.3,5

The majority of children who witness abuse themselves have been abused,6 making it difficult to tease apart the effect of witnessing abuse from the effect of experiencing it. In addition, children living in cities are frequently exposed to out-of-home violence. For instance, children witness 10 to 20% of the 8,000 to 16,000 murders committed each year.7 Martinez interviewed 165 6-10 year old, low income children living in Washington, DC. He found that 19% of the younger children and 32% of the older children had been shot, stabbed, mugged, chased, or threatened or had witnessed these events. Six percent of the boys had been shot and 23% had been mugged at least once.6 Parents were usually unaware of the extent of this violence. In general, studies of the effect of domestic violence on children have not been controlled for subjects’ exposure to violence outside the home.

Effect on Child
The good news is that children who are reared in violent homes do not necessarily become violent parents later on. There is little evidence to support the claim that abuse begets abuse.9 One-third will grow up to follow a pattern of inept, abusive, or neglectful parenting and one-third will not. The remaining third could go either way, depending on circumstance and social stress.10 The bad news is that more than half of children reared in violent homes demonstrate severe behavioral problems and below average social competence. When given the choice, they tend to choose aggressive solutions to problems.11 In adolescence they are likely to engage in high risk behaviors such as drug use, run away, and promiscuity.12

Preschool children react differently than school age children. Even after considerable exposure to violence, they may appear asymptomatic13 or develop only non-specific symptoms of irritability or depression. However, 4 to 6 year old youngsters from violent homes react quickly and fearfully to scenes of confrontation when they engage in structured doll play.4 They try to deny aggressive content or they appear disinterested and decide to stop playing. This suggests significant levels of dysphoria below the surface.

Children reared in violent households tend to identify with either the victim or the aggressor. Children who identify with the victim may become self-punitive, scratching or biting themselves.14 They often think they caused the fight and should have been able to stop it. Those who identify with the aggressor express violent themes in play, wiping out less powerful figures. In real life they often are characterized as bullies. Identification with the aggressor may be the reason why child witnesses to violence are apt to be violent toward siblings15 and why, after the abuser is gone, some children will begin to swear and lash out at the non-abusive parent.

One-quarter to one-half of children are hurt as bystanders when violence erupts or when they attempt to intervene in the struggle. In part, this is related to the fact that the parents have usually been arguing about how to raise the children.5,16 Girls and boys react differently to domestic violence. Girls are more likely to whimper and cry to the abused parent while boys are more likely to disobey or lash out impulsively. Either of these reactions can further engage the abusing parent and place the child at risk for abuse. Children of both genders find it easier to describe the violence than talk about how they feel about it.

Less than half of older children exposed to moderate-to-severe trauma will develop symptoms of PTSD, and many of these will recover without residual symptoms. The outcome depends on the child’s resilience, family support, severity of the trauma, and the child’s closeness to and perception of the event. By and large, symptoms of PTSD are the same in children as they are in adults, including intrusive thoughts, nightmares, increased arousal, restricted range of affect, and sense of foreshortened future. Differences seem related to developmental level. Children are more likely than adults to regress by wetting the bed, sucking the thumb, or using baby-talk. Children’s nightmares are less clearly related to the
actual event. Children play out their anxiety, recreating the traumatic event again and again. This is called repetitive play. \(^9\) Seven-year-old Marty had seen his father punch his mother in the face and fracture her nose. Weeks later, he began to play a favorite game. He would take his sister’s Barbie doll and swing its head against the door jam. Then he would wash the doll’s face and carefully brush the hair back into a pony tail, saying the whole, “Now you’re OK.” Repetitive play indicates the need for psychiatric treatment. Without treatment, the child continues to compulsively replay the trauma for years without understanding the connection to actual events.

Less frequently considered than PTSD, but no less important, are grief reactions and separation anxiety symptoms. \(^7\) If the abusive parent has had a caring relationship, the children can be expected to grieve if there is a separation. This grief is rarely recognized as society views the children as lucky to be out of a bad situation. Separation issues are prominent in instances where one parent has been murdered and the other has disappeared or committed suicide. Young children may have been left alone with a parent’s body all night, frightened and unable to summon help. As sole witnesses to the crime, they may be subject to intense interrogation by the police. They may be abruptly placed in a foster home, losing both parents, clothes, toys, friends, and the old, familiar school. \(^8\) Therapeutic goals are to resolve grief at the loss of the parents, rage at the perpetrator, fear of retribution, helplessness, guilt over not having been able to prevent the crime, and adjustment to new parents and a different environment. Those children who were not directly involved in the violence may deal with many of the same issues but are less likely to be identified as needing treatment.

### Treatment

Children who have been exposed to significant violence deserve a thorough evaluation. This may take several sessions. Some children will not need further intervention unless they become symptomatic. Children with grief reaction or separation anxiety disorder should be treated appropriately. Behaviorally disordered youngsters are likely to need a behavioral management program coordinated between home and school. Behaviorally disordered children should have a complete evaluation as depression or PTSD can accompany or be the basis for behavioral problems.

Pynoos and Eth have developed an effective, brief therapy format for children with PTSD. \(^9\) After forming a relationship, the therapist encourages the child to draw pictures and make up stories. Inevitably, images of the traumatic events intrude into the child’s creative work. The child is encouraged to talk about what happened, the worst moment, who was responsible, and what might have changed the course of events. The child becomes extremely anxious but later feels relieved. The therapist supports the child through the desensitization process, addressing issues of guilt and grief.

Family involvement in therapy is extremely important. The abused parent may suffer from PTSD and be emotionally unavailable to the children. Others may unintentionally feed into children’s anxiety. Children are considered recovered when they no longer hyper-vigilant, can concentrate better at school, have resumed a normal pattern of activity, and are less pessimistic about the future.

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### References

PTSD Among Women Survivors of Domestic Violence in Hawaii


Empirical evidence suggests that between 33% and 83% of Hawaii women receiving services from programs that serve battered women meet diagnostic criteria for posttraumatic stress disorder (PTSD). In addition, PTSD symptom severity is associated with depression severity, lowered self-esteem, and diminished quality of life. Combined with evidence that domestic violence often goes on for years, these findings provide additional compelling reasons why domestic violence screening should be conducted routinely in medical settings.

It has been estimated that between 22% and 35% of women who seek care in emergency departments are there because of domestic violence and that physicians detect only 5% of all cases.1 Extrapolating from the results of a 1992 survey conducted on Kauai, it is estimated that between 14% and 20% of women in the State of Hawaii are victims of domestic violence.2,3 Based on this estimate, at least 49,000 women in Hawaii between ages 21 and 64 were survivors of domestic violence in 1992. Preliminary data drawn from clinical inquiry at an Oahu medical clinic in 1996 are consistent with these numbers and estimates. In their responses on a recently developed trauma history screen, 11 of 60 women patients (18%) at a rural Oahu ob-gyn clinic indicated that they had been "slapped, punched, kicked, or otherwise physically hurt by an intimate partner" at least once.4 Thus, domestic violence appears to be an immense problem in the Aloha State.

Physical injuries are only the most visible reasons why many authors, American Medical Association committees, and AMA-associated organizations have called for mandatory domestic violence screening in primary medical care settings.1,5,6 Every bit as deleterious as the physical effects of domestic violence, however, are its pernicious and long-lasting psychological and emotional effects.

Domestic violence often evokes intense fear, helplessness, and horror in its victims. As a traumatic stressor, domestic violence can cause victims to develop posttraumatic stress disorder (PTSD). PTSD symptom clusters include
(a) reexperiencing the trauma (eg, intense distress when reminded of the trauma, nightmares, and physiological reactivity when exposed to reminders),
(b) avoidance (eg, efforts to avoid thinking about the trauma and avoidance of people, places, and activities that serve as reminders),
(c) emotional numbing (eg, loss of interest in important activities, detachment from others, and inability to experience positive emotions), and
(d) hyperarousal (eg, insomnia, irritability or anger, hypervigilance, and problems with concentration).

To make matters worse, if pervasive symptomatology is still present six to nine months after the trauma, subsequent improvements may be unlikely to occur without some intervention.7,8,9 Because of its high rate of occurrence, domestic violence may be the single most common cause of PTSD in Hawaii. In a study of 50 women residing in a shelter for battered women on Oahu, 55% of the women obtained questionnaire scores that exceed a cut-off score for making a PTSD diagnosis.10 This finding is consistent with results obtained with shelter samples of battered women on the mainland, where PTSD incidence rates have ranged from 45% to 84%,11,12 among 164 battered women receiving support group services from the Family Peace Center in Honolulu, 33% of the women obtained scores that exceed a cut-off score for making a PTSD diagnosis.13 In a project nearing completion, where PTSD symptomatology is being assessed by means of a structured clinical interview, 62 of 75 women (83%) who sought counseling in the past year received a DSM-IV diagnosis of PTSD.14

In addition to being a cause of PTSD, domestic violence can also produce serious clinical depression. PTSD, major depression, and dysthymic disorder have high comorbidity. In the shelter sample of battered women mentioned earlier, all seven women who were severely depressed (with scores above 30 on the Beck Depression Inventory) also had PTSD.10 In two studies of battered women in Hawaii, scores on measures of PTSD and depression were highly correlated (.76 and .73).10,14 Thus, when physicians identify a patient who has been exposed to physical or sexual violence, and the patient "looks" depressed (eg, appears apathetic, has flat affect), there is a strong possibility she also has PTSD. At the same time, if a patient looks depressed, this may serve as an additional "red flag" to physicians that trauma has occurred (and could be ongoing).

Women with domestic violence-related PTSD are also at heightened risk for lowered self-esteem, social avoidance, suicidal thoughts, irrational abuse-related guilt,9 and an impoverished quality of life. Among 68 battered women receiving support group services from the Family Peace Center in Honolulu, PTSD severity was highly correlated with negative self-esteem (.50), social anxiety and avoid-

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and last the time between the span of years, more or one of over women had the abuse of Oahu, on women for a shelter in living to 50 of women mention.

often that violence to a cycle that is often chronic and recurrent over a period of years in the absence of outside intervention. Among 50 women living in a shelter for battered women on Oahu, 81% indicated that the abuse had occurred over a period of one or more years, and the span of time between the first and last incident of abuse was four or more years for almost half of these women. Very similar results were obtained with a combined sample of 168 Hawaii women attending support groups for battered women.

Unfortunately, there is evidence that many physicians are unaware of the seriousness of the mental health consequences of domestic violence. For example, in a 35-page pamphlet on the "mental health effects of family violence" published by the AMA in 1995, PTSD was not mentioned even once. Furthermore, PTSD symptoms of "emotional numbing" and "strong emotional and avoidant reactions" were only mentioned briefly, and only fleeting references were made to "unrecognized anxiety, depression, and other problems." It is hoped this article will raise physicians' awareness of the terrible psychological and medical costs of domestic violence and will motivate physicians to screen for domestic violence on a regular and systematic basis.

References

Table 1.—Men and Women in a Residential Substance Abuse Treatment Program (on Oahu) Who Had Been Physically Hurt by an Intimate Partner

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Men (n=68)</th>
<th>Women (n=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slapped, punched, kicked, beaten up,</td>
<td>60%</td>
<td>87%</td>
</tr>
<tr>
<td>or otherwise physically hurt by an intimate partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Badly injured during the abuse</td>
<td>7%</td>
<td>30%</td>
</tr>
<tr>
<td>Threatened with death or serious bodily harm by an intimate partner</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Sexually abused by an intimate partner</td>
<td>3%</td>
<td>20%</td>
</tr>
<tr>
<td>Stalked by an intimate partner</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>Slapped, punched, kicked, beaten up,</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>or otherwise physically hurt more than 8 times by an intimate partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intense fear, helplessness, or horror during the abuse</td>
<td>17%</td>
<td>60%</td>
</tr>
</tbody>
</table>

A Peaceful Society Begins with a Home Free of Violence

STOP DOMESTIC VIOLENCE

HAWAII MEDICAL JOURNAL, VOL. 55, SEPTEMBER 1996
Pandora’s Box: Open it and Pass it on!
Victim Advocates can Bring Relief to Busy Physicians

Julie A. Owens, BA*

It is clear that physicians and other healthcare providers are becoming increasingly concerned about the short and long term health effects of domestic violence. Unfortunately, it is equally clear that most battered patients, especially those with no visible injuries, still fail to be properly diagnosed and referred to the abuse experts who can offer them safety and support. Discussing partner abuse with patients is frequently compared with “opening Pandora’s Box” and is sometimes avoided by even the most concerned providers due to the time-consuming and complex issues involved. Regular abuse screening with on-the-spot support for identified victims must become routine procedure for physicians.

The well documented, potentially life-threatening effects of ongoing abuse create a responsibility on the part of all physicians to become thoroughly familiar with assessment techniques and with community agencies that can begin helping identified victims before they leave the medical setting. Domestic violence programs offer a variety of specialized services which health care professionals typically cannot provide, such as comprehensive safety planning, protective shelter, restraining order advocacy, group support, supervised child visitations and legal assistance.

In this real world of back-to-back patients and little, if any, formal education on the topic, it is unrealistic and unreasonable to expect physicians to do it all. Nevertheless, it is imperative that individual doctors pursue basic domestic violence training. Physicians can easily learn to routinely assess for signs of psychological, sexual, and physical abuse, to interview victims sensitively, to thoroughly document injuries and symptoms, and to preserve evidence for legal purposes. But the most important role of the health care provider in terms of actual patient safety and support is in making appropriate follow-up referrals.

Contrary to what many physicians may fear, a major time commitment is usually not required to effectively address abuse with a patient and discuss the resources. “Quicker than you can put on a Band-Aid,” says physician Anne Flitcraft of the University of Connecticut, “you can acknowledge the violence, you can assert that this is illegal, not her fault, and that a lot of women are in her situation. You can educate her about the community-based resources available to her, and ask ‘Are you safe?’”. Lyn Lee, a Hawaii abuse survivor and a social worker, has helped train medical students by sharing her experiences and her professional expertise. “For years I encountered medical professionals who were not informed about the issues that affected my health. More importantly, they did not know how to give me referrals. Doctors seemed reluctant to even discuss abuse. Fortunately, my present physician is very aware of the dynamics of domestic violence and has served as a significant support in my continuing healing process.” Survivors routinely report that the best “medicine” ever prescribed for them was a referral to a support group where they met other battered women and were educated on the dynamics of abuse.

Any time abuse is suspected by a health care provider, the patient should be offered the opportunity to speak with a victim advocate. If she agrees, then the Pandora’s Box of issues can be turned over to experts who are trained to address each of her multiple safety, support, and legal considerations. Working with abuse victims, whether they are still in a relationship with their abuser or are being stalked or threatened by an ex-partner, is tricky at best. Safety and confidentiality can easily and inadvertently be jeopardized. When this happens, providers may lose the only opportunity they will ever have to help.

Advocates can encourage a patient to confidentially talk at length in an unpressured atmosphere, whereas health care providers are usually limited by time constraints. Because advocates are not mandated to involve the police or others, a victim can also speak freely without fear of retaliation from an abuser who might punish her severely for disclosing. The advocate will help the patient design a comprehensive, personalized safety plan. The victim will learn about her legal rights and what battered women can and cannot expect from the criminal justice system. Finally, her options will be discussed.

On Oahu, a system is available to provide immediate on-the-spot crisis counseling for battered women in health care settings. Dr. Lisa Hendrickson, an Emergency Department physician with Kapiolani Medical Center at Pali Momi, has been an ardent supporter of the crisis team. “Sometimes I just don’t have time to deal with the cases,” she says. “For example, one night just recently I had three battered women show up in one hour. One had been beaten, sexually assaulted, held hostage for 24 hours and had children who had been left at the scene. Another was a sixteen year old whose boyfriend had knocked out some of her teeth for the second time. The third one claimed she had been assaulted by a stranger while jogging at 11:00 pm. She was pregnant. Of course, it was domestic violence. I couldn’t possibly handle every detail of cases like these without outside support. Even if I could,” she explains, “the victims are much more likely to listen and relate to someone else, especially a

*HOPE Domestic Violence Consultants, Executive Director, Pacific Center for PTSD, Project Director, Trauma Survivors Project Hospitality House Transitional Shelter for Battered Women and Children, Manager

Continued on Page 168
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Identifying Family Violence: A Community Prototype Incorporating Native Hawaiian Values and Practices

G. Noelani Wilcox, MS, RN, CNS; Laura Jean C. Armstrong EdD, MPH, RN

Background

One of the major public health problems facing both the nation and Hawaii is family violence. The report entitled Current Status of Training Programs in Hawaii for Health Professionals on the Assessment of Family Violence, March 1995, written by Susan Maley, reiterated that family violence is a leading cause of physical and psychological trauma and death for both women and children. More than half of the children whose mothers are battered are also victims of physical abuse. Families who experience family violence seek health care eight times more frequently than the nonviolent families.

The Hawaiian community was significantly affected by the abuse of its women and children. Hawaiian women’s exposure to family violence was higher than their percentage in the total population of the state - 13.5% of population vs. 20% of victims (State Commission on the Status of Women, 1993). The Hawaii Kids Count Data Book, 1994, also reported that Hawaiian children were more at risk of abuse than any other ethnic group and that the rate of child abuse is 33% higher than their percent of population (18% of child population vs. 27% of victims).

Response: Manual on Identifying Family Violence

In 1994, the Community Health Nursing Division and the Queen Emma Foundation became partners in the development of a training manual* to identify family violence in a culturally sensitive manner. Published in 1996, the purpose of this manual, Identifying Family Violence: A Community Prototype Incorporating Native Hawaiian Values and Practices, was to design an approach to improve the identification of family violence cases by health care professionals and to encourage disclosure by families within the native Hawaiian community.

Our assumption is that a culturally integrated approach is a necessary component of a community’s strategy to address this escalating problem. This manual is a pioneering effort which health care professionals can adapt, expand, or refine in their work with native Hawaiians. However, we believe the values and practices described in the manual have universal application and can be incorporated in one's work with non-Hawaiians as well.

Basic Assumptions: Foundation of Manual

Assumptions which guided the development of this manual include the following:

About the Family

• Families are the foundation of a safer, non-violent society.
• Family members empower each other by practicing the true meaning of aloha on a daily basis.
• When any member of the family abuses another or is the object of abuse (spouse, children, elders, other dependent adults), the family’s safety and ability to interact in the spirit of aloha is threatened.
• To preserve the aloha within the family and to create a safe environment for the rest of the members, they may need to physically remove themselves from the situation or may need to have the person inflicting pain removed from the home.
• The extended family may be able to provide kokua (help) so that all members have a safe place.
• Time away gives every family member an opportunity to rediscover the power within themselves and to regain control of their lives in a safe environment.
• Right actions occur when individuals within the family ho oponopono “to make right” within themselves.

About Health Care Professionals

• Health care professionals are oftentimes the first persons in the community to whom a family will reach out.
• Health care professionals are in a pivotal position to discover, treat, and/or refer for help persons in family violence situations.
• When health care professionals approach family violence situations with an enlightened heart, their ability to help is enhanced.
• A health care professional develops an enlightened heart by engaging in practices that nourish his or her aloha.
• Mana is the spiritual life force which enables health care professionals to interact with others, including clients, in the true spirit of aloha.

About Cultural Integration

• A culturally sensitive and competent approach is recommended in family violence situations, particularly in Hawaii where the population is multicultural.
• The Hawaiian culture encompasses values and practices that can be applied universally to native Hawaiians as well as other populations.
• As the host culture, native Hawaiian principles, values, and practices should be incorporated into health care delivery for the benefit of our indigenous people.

*For information on obtaining the manual, contact Laura Armstrong, State of Hawaii, Department of Health, Community Health Nursing Division at 566-4131.
About *Pule* (Prayer)

Throughout the manual, *pule* is used as a means of seeking divine empowerment, guidance and inspiration. Developing an understanding of one’s spirituality is inherent in the process of using *pule*. Religion is often the bridge to understanding one’s spirituality.

*Pule* is an essential part of the ho o ponopono “to make right” process when violence has occurred, since there is a disconnection of one’s spiritual being from the physical.

The manual acknowledges all practices and beliefs which assist health care professionals and their clients in this process of deepening spirituality.

The Process: *Hana Pono Ka Puuwai Malamalama* (The Enlightened Heart Acts Accordingly)

Personal insights into one’s principles, values, and practices and that of the client or family assist the health care professional in working with family violence. Effectiveness is enhanced when the health care professional is able to develop *aloha* with the presenting family member. This process, therefore, was designed to emphasize caring communication from an enlightened heart. Phases in this process include: 1) *pule wehe* (to prepare); 2) the interview: encouraging disclosure, 3) the examination, 4) closure, and 5) *pule hokau* (to release).

I. *Pule Wehe* (to prepare)

Health care professionals are in a unique position to assist families in crisis. Oftentimes they are the first persons outside of the family to find out about the violence. In order to be there for a family, the health care professional must demonstrate *hana pono ka puuwai malamalama* (an enlightened heart acts accordingly).

*Malamalama* or enlightenment occurs when one is in touch with mana (spirit). *Malama* (caring) is the root of *malamalama* (enlightenment). Acting with an enlightened heart means:

- Watching not only with the eyes, but with the heart; listening not only with the ears, but with the heart; speaking not only through the voice, but from the heart; thinking not only with the mind, but with the heart; doing not only what protocol dictates, but what the heart guides one to do.

II. The Interview: Encouraging Disclosure

During the interview, building *aloha* and establishing trust is critical. Building *aloha* involves creating a sense of time. Take advantage of the time you have to nourish the client’s *mana* by building *aloha* and establishing trust; this will facilitate the client’s ability to connect with his/her internal clock and spiritual knowledge of the *ohana* family. Each visit is an opportunity for the health care professional to encourage disclosure; express concern for the well-being of all family members; and provide information about the danger of the situation, resources, and options. Several visits may be required before the client is ready to transform the family situation.

Building *aloha* involves creating a sense of place. Regardless of the setting (emergency room, doctor’s office, clinic, or home), the interview must be conducted in privacy. Have another professional meet with any accompanying spouse, partner, or other family member, or friend especially if they appear uncooperative. Call security only as a last resort, as this may increase the risk of later violent retaliation against the client.

Building *aloha* involves creating a sense of space. Enhance the client’s spiritual space by, for example, having the client use *ha* (breath cycle) to decrease distraction, recite a *pule* together or send forth a *pule* to the client in silence. Enhance the client’s mental space by clarifying the purpose of the interview and what the client can expect from the health care professional; discuss confidentiality and its limits; avoid labeling. Enhance the client’s emotional space by focusing on keeping self open in order to detect client concerns that remain unverbalized and to deal with any risks/dangers/fears; develop and use an assessment questionnaire as a routine tool to uncover family violence; be versatile in your interviewing approach.

III. The Examination

The examination is another opportunity to encourage disclosure. However, it is important to note that the examination also encompasses several medico-legal procedures which include:

- Obtaining and documenting clearly and accurately the history of injury, conducting and documenting clearly and accurately the physical assessment, conducting and documenting clearly and accurately the emotional assessment, conducting and documenting clearly and accurately the assessment of present danger, collecting evidence, and treatment.

IV. Closure

The overall goals of establishing closure is to reinforce safety and empowerment by:

1. Reaffirming concern for the well-being of all family members.
2. Providing information about the danger of the situation, resources, and options.
3. Respecting the family member’s chosen action.

V. *Pule Hoku* (to release)

After the client has left, the health care professional may make the transition to the next client by performing a cleansing ritual. As one is performing the handwashing ritual, consider reciting the following thought:

> I am washing away any negativity or judgments attached to (name of client) and their situation. I, (health care professional), am cleansed, purified, and protected.
>
> May all ties to (name of client) be cleansed and purified.
>
> Remove all negative thoughts, emotions, and attachments whether known or unknown.

Summary

The manual, *Identifying Family Violence: A Community Prototype Incorporating Native Hawaiian Values and Practices* is a pioneering effort which health care professionals can adapt, expand, or refine in their work with Hawaiians and non-Hawaiians as well. Our assumption is that a culturally integrated approach is a necessary component of a community’s strategy to address this escalating problem.

Family violence is a virus which threatens all of us. It weakens the *pohai ke aloha* (circle of aloha) which binds the family together. When the *pohai ke aloha* is weakened, each family member’s *mana* (vital force) declines. When a family’s *mana* is in decline, the *lokahi* (harmony) within the family and our community is disrupted.

We, as a community, a society, a nation, cannot afford to stand by and condone violence within the family. Ultimately, we all suffer when our families are hurting.

*Hana pono ka puuwai malamalama*. An enlightened heart acts accordingly.
A Police Officer’s View of Domestic Violence

Detective Bernie Campbell, Family Violence Detail, Honolulu Police Department

When I was a rookie officer with Honolulu Police Department (HPD) in 1975 responding to domestic violence cases, there seemed to be very little I could do at these situations. The Spouse Abuse law of 1973 permitted officers to arrest if the abuse was committed in their presence.

Frequently, I was looking at victims with swollen, puffy eyes; a bloody nose, bloodied mouth, or various marks on the face, neck or arms. I looked at frightened children, who looked back at me, expecting someone or something to help them.

All I could do was order the abusive ones (if they were married couples) to leave the home for a cooling off period of three hours. And I walked away. Sure, I made a police report; but not having a strong law and the authority to act, I could do little else. The perceived inaction conveyed to everyone in those families that this behavior was acceptable because there were no consequences to the batterers. Some of those children likely grew up to be this generation of abusers and victims. Now, as a detective in the Family Violence Detail of HPD, I am seeing them again in all kinds of police reports.

What we’ve learned in the past 20 years is that Domestic Violence is not only a “family matter” or “social” problem, it is a deadly criminal problem. Its ripple effect extends into crimes in our schools, our workplaces and our community. It destroys lives, families and communities, and is transmitted to the next generation to continue the cycle of destruction.

Current Law

Currently, Section 709-906 of the Hawaii Revised Statutes (HRS) makes it a crime to physically abuse a family or household member, defined as “spouses or former spouses, parents, children, and persons jointly residing or formerly residing in the same dwelling unit.” This is punishable as a misdemeanor with a mandatory minimum two-day jail sentence for a first conviction; and a thirty-day jail sentence for a subsequent conviction within a year. Officers don’t need to witness the offense to make an arrest. The law authorizes officers to make an arrest based on reasonable grounds.

The cooling off period has been extended to twenty-four hours or longer, if it’s the weekend. The law further mandates an arrest of someone who refuses to leave the premises or returns prior to the end of the cooling off period.

Arrests went from less than 300 arrests in 1986 to nearly 3,000 in 1992!

HPD’s #1 Goal

Chief Michael S. Nakamura has declared the reduction of domestic violence to be the Honolulu Police Department’s (The Department) number one goal for 1996. The Department recognizes that an effective law enforcement response can reduce homicides, injuries and recidivism and convey a strong message that violence in the home is a serious crime that will not be tolerated.

The immediate goals of an effective response are to:
1) Stop the Violence
2) Increase Safety of Victims and Children and
3) Hold the Abuser Accountable.

Several strategies have been initiated towards the accomplishment of the Department’s goals.

Policies

The Department’s policy for enforcing the Abuse of Family or Household Member law (709-906 HRS) has been that of “mandatory arrest”. This means that when officers have probable cause to believe someone has physically abused a family or household member, the officers shall effect an arrest on the perpetrator.

And most recently, the Department strengthened its policy on the issue of Restraining Order violations by directing officers to effect arrests for these violations of court protective orders whenever probable cause exists. Although restraining orders or TROs are not and never will be bullet-proof vests, this pro-active arrest policy certainly puts more “teeth” into the court orders as well as some immediate consequences for violators.

Training

In January of 1996, the Department began a mandatory two-day Domestic Violence Training for all field officers and supervisors to enhance their ability to respond effectively, safely and consistently to domestic violence cases. This intensive agenda is designed to provide officers with the most recent updates on domestic violence laws and procedures as well as understanding the complex dynamics of domestic violence and its impact on victims, children, abusers and the entire community. The curriculum addresses abuse of family or household members, child abuse, dependent adult abuse, custodial interference (parental kidnapping), court orders of protection, and community resources for victims of domestic violence. As of July, over 500 HPD officers have received the training, and generally, the response has been positive. It is anticipated that approximately 400 - 500 more will be trained before the training program concludes in January 1997.

Victim Assistance and Intervention

The Department recognizes that arrest alone cannot interrupt the cycle of violence and increase the safety of victims. Victims must be informed of the resources available in the community, particularly of shelters, the availability of restraining orders, legal advice, emotional support and counseling.

In February 1994, the Department, in conjunction with the Hawaii Emergency Abuse Response Team (HEART) through Parents and Children Together, has had a “DART” Project (Domestic Abuse
Response Team), consisting of a counselor and an officer. They respond to domestic violence scenes to offer crisis intervention services to victims. Victims receiving DART interventions were tracked by the Prosecutor’s Office and were noted to participate more in prosecutions to obtain needed counseling/assistance for their abusive partners. Victims also reported a more positive perception of the police. Additionally, department policy directs officers to make every effort to provide victims with information via a “HELP” card, printed by HPD, which lists the resource agencies for victims to contact, or by connecting them to available community projects such as DART.

A new Grant Project will extend the DART concept by the end of 1996 by providing a “one-stop shop” for victims, where a variety of services will be made available within one location.

**Statistics**

Recently the Hawaii State Attorney General’s office released the results of a study of domestic violence related homicides in Hawaii from 1985-1994.*

<table>
<thead>
<tr>
<th>Table 1: Cases: Domestic Violence-Related Homicides in the State of Hawaii by County, 1985-1994.</th>
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<td>County</td>
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<td>Domestic argument</td>
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<td>Child abuse</td>
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<td>Other argument</td>
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<td>Love triangle</td>
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<td>Break up</td>
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<td>Divorce</td>
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<td>Other*</td>
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<td>Under the influence of drugs</td>
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<td>Psychiatric problems</td>
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<td>Gagged to keep from crying</td>
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<td>Revenge</td>
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<td>Total</td>
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Note: Percentage do not total 100 due to rounding.

*Includes arguing over the offender’s advances, throwing over a clift after rape, arguing over victim’s girlfriend, killing to demostrate to the offender’s girlfriend her fate if she left him, parents arguing—offender attempted to shoot father but shot mother instead, burning down residence while victim was still inside.

**Includes the circumstances of all homicides for all offenders and victims.

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<td>Total</td>
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<th>Table 4: Offenders: Domestic Violence-Related Homicides in the State of Hawaii by Sex, Age and Race, 1985-1994.</th>
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<td>61 and older</td>
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<td>Total</td>
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**Making a Big Difference**

In past years, police officers have been justifiably criticized for their weak response to this most confusing and frustrating crime. But as we’ve learned more about the complex dynamics involved, and the current research about what really works, we have a clear vision of our pivotal role in making a big difference by our proactive response to domestic violence cases. But the job is not ours alone, nor that of the Criminal Justice System only. Our entire community needs to join together in sharing the responsibility, collaborating in the solutions, and committing their efforts and resources to ending domestic violence.

Help us! Together we make a big difference!

* Hawaii Crime Brief, Dept. of the Attorney General, Crime Prevention and Justice Assistance Division. April 1996. Permission for reprint granted. Note: Number of cases vary in Table 1 from Tables 2 and 3 is due to the variable of more than one victim or more than one offender in a case. In Table 3 some homicides were due to multiple circumstances.
The Community-Based Outreach Program
A Vital Resource for Medical Professionals Working with Victims of Domestic Violence

Catherine A. Bruns MA, MFCC, Program Supervisor; Debbie Garcia, Program Coordinator

The U.S. Surgeon General reports that battering is the single-most common cause of injury to women resulting in more injuries than automobile accidents, rapes and muggings combined. The American Medical Association reports that 22% to 35% of all emergency room visits by women are caused by abuse. In Hawaii, almost 100,000 days of hospitalization, 30,000 emergency room visits, and 40,000 trips to the doctor every year are the result of domestic violence. Medical professionals are often the first point of contact for battered women. Those in the medical profession are adept at healing the physical wounds and ailments, but often don’t know how to begin to heal the emotional injury or to help a woman become safe. Doctors, nurses, and other medical personnel may be intimidated by the subject of domestic violence, as are many others. The Community-Based Outreach Program (CBOP), a program of Parents and Children Together (PACT), can offer vital assistance for medical professionals who are treating battered women.

CBOP is a service which provides crisis intervention, education, support, information and community referral to victims of domestic violence. A trained and highly skilled domestic violence counselor will meet with a domestic violence victim at any safe location, including hospitals, physicians’ offices or any other community location. Safety, for client and counselor, is primary, thus CBOP counselors will not meet clients in their homes. If no safe location is available, or if the client prefers, counseling is provided by telephone.

Historically, the CBOP phone number was available only to referring professionals. Currently, however, in an effort to reduce barriers for battered women to obtain assistance, CBOP will accept referrals from both professionals and clients. This also makes it easier for medical professionals, as the CBOP number and information can be given directly to the patient, and she can call at her convenience. However, CBOP welcomes referral calls from medical professionals as the information provided by physicians is often extremely helpful.

CBOP began in July of 1995 and since that time has served more than 150 community-referred victims of domestic violence. CBOP’s objective is to empower and educate those who have been victimized by domestic violence. Crisis theory, which the program is based on, says people are more amenable to change during a time of crisis. CBOP, therefore, responds during these crisis times with the intention of providing the tools and resources for change. For many clients, this is the first time they have received information about the cycle of violence. With more information, battered women are better equipped to take steps to ensure the safety of themselves and their children. During an intervention, the CBOP counselor assesses the client’s situation and provides intervention based on the nature of a client’s crisis. The client’s safety is considered foremost, thus the counselor will always create a safety plan with the client whether she is able to leave the violent situation or not.

CBOP is a vital resource for physicians. Victims of domestic violence who seek primary care from their personal physicians and from emergency rooms will have the opportunity to speak with a trained professional about the violence plaguing their lives.

A CBOP counselor may be reached by calling the voice mail pager at (808) 549-8462. A counselor will return the call within five minutes. CBOP services are available Monday to Friday 8 am to 1 am, and Saturday and Sunday, 5 pm to 1 am.
An Intervention Model for Child Witnesses of Domestic Violence

Jerry Coffee BS and Allana Wade Coffee, MSCP
PACT Family Peace Center

The PACT Family Peace Center Children’s Program has provided psychoeducational group and individual counseling for child witnesses of domestic violence since 1990.

Definition
The PACT Family Peace Center defines domestic violence as an intimate partner’s systematic attempt to gain or maintain power and control over another person through intimidation, manipulation, humiliation and violence. Physical abuse is only one part of a whole system of abusive behavior. Emotional abuse, physical and social isolation, economic abuse, sexual abuse, using children as leverage, threats, male privilege and intimidation are other parts of the system of abuse.

The act of witnessing violence includes both seeing and hearing physical, emotional, verbal, sexual abuse or property damage. The act of experiencing violence refers to being physically, emotionally, sexually abused or neglected.

Emotional abuse and neglect can be equally impacting as physical abuse. The PACT Family Peace Center provides intervention for children who have witnessed and/or experienced family violence.

Prevalence
Nationally, women experience an estimated 572,000 acts of violence by their male intimate partner. In 1993, the Hawaii State Commission on the Status of Women estimated that 49,000 women in the State of Hawaii are victims of domestic violence. This was considered a conservative estimate.

It is estimated that approximately 90% of children living in violent homes are aware of the violence. If 49,000 victims have an average of one child, then approximately 44,100 children in Hawaii have witnessed domestic violence.

Clinical Considerations
There are three major clinical areas to consider:
1) the child witnesses’ development of aggressive behavior,
2) posttraumatic stress disorder, and
3) altered relatedness.
These issues may effect the normal physical, moral, and cognitive development of school age children and toddlers.

Posttraumatic Stress Disorder (PTSD) and Health Related Problems
Child witnesses of domestic violence may experience PTSD symptoms, which include a restricted range of affect, a sense of foreshortened future, difficulty sleeping, difficulty concentrating, hypervigilence and exaggerated startle response. Some health related problems include allergies, headaches, stomach problems, asthma, enuresis, and phobias.

Altered Relatedness and Problems in relationships
Exposure to family violence may contribute to a child’s ability to establish significant trusting relationships. A parent’s chronically inconsistent emotional or physical availability adds to the child’s anxiety and uncertainty which may lead to mistrust and poor ability to empathize.

Aggressive Behavior
Children who have been abused or neglected are 38 percent more likely to be arrested for violent crime than nonabused or non neglected children. Children who witness chronic violence may also become desensitized and tolerant of violence and self-blaming. They may also develop gender-rigid and distorted beliefs and attitudes which may result in rationalizations involved with being a perpetrator.

Intervention
One effective intervention is a psychoeducational group which challenges the child’s beliefs and attitudes about aggressive behavior and family violence. This group also facilitates the learning of appropriate nonviolent skills for conflict resolution. PACT Family Peace Center’s groups are psychoeducational. They were designed to provide an emotionally safe and consistent environment within which participants can share and examine their beliefs and attitudes about aggressive behavior and family violence. PACT Family Peace Center’s counseling approach is culturally relevant and sensitive to the needs of Hawaiian Pacific Islanders as well as other populations.

Children’s Groups

Group Process
PACT Family Peace Center defines the group process as a combination of the relationships that members establish with each other, the facilitator, as well as the nature in which members integrate group content. Chronologically, group process refers to the events occurring in an individual session as well as the collective, therapeutic sequence of a 15-week cycle.

Children’s groups limited to ten to fifteen participants and two to three adult facilitators. The small group size allows the children to bond sufficiently and to maintain a consistent environment. The group process involves a continuum of sequential healing that includes:
• Trust building
• Acknowledging violence and validating feelings
• Healing
• Discovering new ways of coping with violence and
• Integration.
Trust Building

While trust building is the initial stage in the group sequence, it is frequently a recurring phase. Group discussion and activities, which work to align members to each other, may occur at any point in the group sequence. Validation by peers and facilitators specific to the trauma of witnessing violence appears to provide comfort to participants. The group experience is designed to normalize participant’s reactions to violence and to diminish isolation, thereby increasing self-trust.

Acknowledging Violence and Validating Feelings

Children often learn to minimize, to blame themselves or the victim and to deny abuse and violence they have witnessed or experienced. Participants are encouraged individually and as a group to examine different types of abuse, which include emotional, verbal, physical, sexual and property damage. The goal of acknowledging the violence and validating the child’s feelings and experiences, is to decrease their shame and personalization of the abuse.

Healing

Trauma is a common effect of witnessing and experiencing abuse and violence. Common symptoms associated with trauma include cognitive distortions which are assumptions and faulty beliefs that often lead to impaired self-esteem. Children displaying trauma symptoms often form rigid, dichotomous or “black and white” images of the world and themselves. The group sessions are designed to help children process and discard beliefs that minimize their range of coping. Participants are taught that violence may be intergenerational and are encouraged to choose to live non-violently.

Children who witness the abuse of a parent for prolonged periods of time may develop feelings of powerlessness and an inability to recognize choices. These feelings may be further reinforced as women and children encounter a system which often appears to excuse violence or fails to keep victims safe. Children’s groups work to instill both personal power and awareness of choices regarding personal safety and behavior.

Discovering New Ways of Coping with Violence

Typically, child and adolescent victims and witnesses of domestic violence respond to conflict with either extreme externalized or internalized behaviors. Parents often request immediate skill building for their children in the area of anger management. It appears that group participants are rarely willing to discuss and integrate positive behavior in initial or even mid-group sequence. They seem to first find congruence and validation in information specific to their own experiences with family violence. As children make connections between their own behaviors and the violence they have witnessed, they become more willing to explore proactive versus reactive responses.

Often, children and adolescents who have been traumatized by domestic violence exhibit a cluster of symptoms associated with attention deficit. Parents learn that as children adapt to the continual crisis of domestic violence, a specific pattern for life style and personality develops. Being “in crisis” and the energy or “rush” which it provides become the primary focus or impetus for being engaged in life. After having been conditioned to this rhythm, children may re-create the “rush”.

Anger management concepts in the group refer to the concept that families and individuals experience anger and violence in a cycle. This cycle includes a honeymoon period, a tension building period and an eventual explosion period. Group members learn to recognize tension building in their family and themselves. Group discussions and activities work to move children closer to being conscious rather than unconscious of feelings and behaviors. Group focus on tension building assists children in learning to keep safe and out of violent situations as adults move from tension building to explosions. Children are taught that explosion or conflict is a part of life. However, violence and abuse need not be inherent in conflict. An explosion need not be violent. Discovering new ways focuses on identifying healthy, nonviolent conflict resolution skills, including time-out.

Hypervigilance, the constant scanning of the environment for physical or emotional hostility, is also a symptom of trauma. It is a coping skill that reinforces an external focus and locus of control, which may lead to learned helplessness. This curriculum is designed to teach the participants to develop an internal locus of control and self reference. By creating a safe and consistent environment, the group encourages children to refer and attend to their feelings and thoughts.

Children who grow only in response to an external locus of control remain at risk for perpetuation of the cycle of violence. Evidence that group members have begun the process of integrating self reference includes taking responsibility for their own actions, attention to body cues, reference to and use of safety plans.

Integration

Throughout the group cycle, participants are provided with opportunities to integrate the curricula with their personal experiences. Although the group curricula is a sequential design, certain topics are recurrent. Trust and safety issues frequently require additional time to process and address. The 15-week cycle is a modest period of time considering the length of time that clients have been exposed to abuse and violence.

Parent Group

Children who have witnessed abuse and power imbalances among adult family members need to experience the family system differently if they are to heal. Parental support is highly recommended. Therefore, children 13 years and younger are not accepted to the Children’s Program without their parents participation in both adult support group and a parent group.

The parent’s group and children’s group concurrently address the same issues. Communication between children’s group facilitators and the parent’s group facilitators is constant. Parent motivation and insight appear to be at their fullest potential as a result of the validation and support generated in the parent group. This provides them with the opportunity to offer continuing and appropriate support to their children. Because the parent’s curriculum is based on the premise that violence is never appropriate in disciplining children, nonviolent discipline and parenting skills are taught.

An awareness of the effects of witnessing violence may elicit in parents feelings of guilt and shame about being a “bad” parent. The parent group provides a nonjudgmental environment for parents to explore parenting issues that relate to the effects domestic violence has had on their children. Within the group there may be former victims and former perpetrators who are brought together under the mutual concern of understanding their children’s experiences and helping them to heal. Parents are encouraged to let go of shame and guilt by replacing them with new skills and support.

Program Evaluation

The Children’s Program uses a multi-axial approach to assessment and evaluation. They include interviews, house-tree-person

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drawings, the Child Behavior Checklist and a Group Interaction Client Assessment (GICA).

The Child Behavior Checklist (CBCL) assesses parents’ perceptions of their children’s behavior by responding to a 113 item questionnaire relating to potential behavior problems. The Children’s Program has been using the CBCL as a pre and post test measure of program effectiveness.

The GICA is a pre and post test that uses a Likert Scale to measure aspects of the healing process from 1 (poor) to 5 (very high). The GICA is administered immediately following the intake assessment and again following the 15-week group cycle. Each item is scored on the basis of observable behaviors and self-reports of the child. The GICA attempts to assess client development in self esteem, safety, understanding of domestic violence, anger management skills, and social relationships.

Preliminary examination of the data suggest a significant decrease in externalized behavior upon completion of the group cycle. Additional research is currently being conducted.

Conclusion

The literature indicates that witnessing domestic violence can produce cognitive and social delays in children’s development, increase their potential for violent and aggressive behavior, limit their ability to establish trusting and empathetic relationships and perpetuate the cycle of violence. The purpose of the Children’s Program is to provide participants with the support and tools they require to interrupt and stop the intergenerational cycle of violence.

References

Advocates
The Legal Hotline
It was the first call of the day. “Domestic Violence Legal Hotline. This is Chris. Can I help you?”
She began speaking in a clear, confident voice. “A friend told me you help women who are afraid. Is that right?” “Yes. Are you safe?” Silence. Then she sobbed. “No, I’m not safe. I’m very, very scared.”
Two attorneys, three paralegals and University of Hawaii pro bono law students staff the Legal Hotline. They express their concern for frightened callers, then tell them about their legal rights and choices and the consequences of those choices. Legal Hotline callers are often facing the most difficult decisions they will ever make.
Last year DVCLH answered 3500 Legal Hotline calls—calls from women and men who needed help and/or information.

Family Court Cases
Terminating a relationship with an abusive partner can be a complex and dangerous process. Batterers typically do not let go easily. DVCLH understands the dynamics of domestic violence. Staff knows how the laws and the system in our state can protect and support victims. DVCLH attorneys and paralegals provide divorce and post decree legal services.
Within 15 days after a Temporary Restraining Order is issued, a victim must return to court and face her abuser. The duration, terms and conditions of the protective order, as well as temporary child custody and visitation rights may be decided at this hearing. DVCLH attorneys represent victims at this proceeding.
Last year DVCLH represented 493 battered women in Family Court and served 1107 children, helping them and their mothers get free and safe.

Persons in Need (p.i.n.) Grants
She had a master’s degree, a good job and made much more money than her abusive husband. From the shelter she called DVCLH to ask for financial assistance. Rather than risk abuse, she had turned over her paycheck to him. Now she needed help with a rental deposit on a new home for her and her children.
Oahu battered persons can call DVCLH for financial help with rent, utilities, medical and other emergency expenses. These grants, intended to help victims get safe and rebuild their lives, are generously provided through The Hawaii Community Foundation by the James and Winifred Robertson Memorial Fund.
In 1995 DVCLH provided 85 battered women with financial assistance.

Domestic Violence Task Force
DVCLH facilitates Oahu’s DV Task Force, organized to improve our community’s response to partner abuse. Caller I.D., police and judicial response, and batterer psychoeducational program guidelines are some of the topics addressed by the 20+ member Task Force. H.E.L.P., Handbook of Emergency and Life-Support Programs - a comprehensive directory of Oahu resources for victims of domestic violence - was produced in 1995.
5,000+ H.E.L.P. Handbooks have been distributed to doctors, attorneys, police, and other city and state service providers.

System Reform
DVCLH’s Executive Director continues to be an expert witness for both defense and prosecution in domestic abuse cases. She has also been elected to the boards of Alliance for Health and Human Services and Hawaii Women’s Political Caucus. She was appointed by the Governor to serve on the Sexual Orientation and the Law Commission. Each year she helps draft and support the passage of laws to protect women and children.

Educates
Training
DVCLH Community Educator and Executive Director make statewide and national presentations. DVCLH is fully funded to provide free training for service providers.
Last year DVCLH spent 814 hours out in the community - educating police, social service professionals, civic groups, teens, immigrants, and students. DVCLH produced and distributed 13,611 brochures for victims, 3,871 brochures for batterers and 7,815 Advocacy in Action newsletters statewide.

Consulting
DVCLH shares what it has learned about domestic abuse - with government officials, public and private sector service providers and the media.
In 1995 about 1600 phone calls and 516 hours involved consulting.

Public Awareness
Every time partner abuse takes a life in the state of Hawaii, DVCLH, City & County of Honolulu, Catholic Charities and AmeriCorps cosponsor Oahu’s silent march: Remember the Dead. Cherish the Living. Part of a national domestic violence public awareness effort, Clothesline Project Hawaii is cosponsored annually by DVCLH and the City and County of Honolulu.
Through collaborative efforts with the City and County of Honolulu, and with funding from First Hawaiian Bank Foundation and the U.S. Dept. of Health and Human Services, in 1995 DVCLH

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launched a Plan for Your Life public awareness campaign.
Radio and television public service announcements, brochures, posters, bus posters, and over 200 hours of on-site trainings have all emphasized domestic violence doesn’t just wound and scar its victims - emotionally, spiritually, physically. Domestic violence kills. Our community must help victims “Plan for Their Lives.”

Administrates
Hard work doesn’t always feel that focused or seem that important and noble—typing, faxing, meeting, writing, phoning, filing, budgeting, xeroxing—day in and day out. And when budgets get cut and battered women continue to die, sometimes hard work seems to be wasted.

Certainly, the task at hand is formidable. The hard work is about stopping violence and oppression. But the mission is ever clear.
DVCLH, sister agencies, and countless women and men all across the state together are sculpting a new society - where women, children and men are safe and cherished.

Growing to meet all your healthcare needs

St. Francis Healthcare System of Hawaii

- Obstetrical and Gynecology Services
- Women’s Addiction Treatment Center of Hawaii (W.A.T.C.H.)
- The Heart Center, including Heart Surgery, Specialty Cardiac Catheterization and Cardiac Rehabilitation
- Hawaii’s only Transplant Center, specializing in heart, kidney, liver, pancreas and bone marrow transplants
- Centers for Diabetes and Liver Disease
- Advanced Diagnostic Imaging, including MRI
- Renal Institute - largest hospital-based dialysis program in the nation
- Cancer Institute - Radiation Oncology, Cancer Screenings, Cell Separator and Tumor Registry

St. Francis Medical Center
HONOLULU 547-6011

St. Francis Medical Center - West
EWA BEACH 678-7000

Since the 1927 founding of St. Francis Hospital in Nuuanu Valley, our ohana has been growing to meet the diverse healthcare needs of Hawaii’s people. Now, with two state-of-the-art Medical Centers on Oahu and an array of community services, including Hospice care, St. Francis Home Care, Health Services for Senior Citizens and parish nurses, we really are where you are when you need us.
| Service                     | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4pm | 8am-4police
Council Highlights

August 2, 1996
Roger Kimura MD, Secretary

The meeting was called to order by Dr Carl Lehman, President at 5:33 pm.
Those present were J. Spangler, President-elect; R. Kimura, Secretary; L. Howard, Treasurer; F. Holschuh, Immediate Past President; AMA Delegates: C. Kam, R. Stodd; AMA Alternate Delegate: A. Kunimoto; Speaker: H.K.W. Chinn; County Presidents: P. Blanchette - Honolulu, E. Bade - Hawaii; M. Joshi - Maui; T. Smith - W. Hawaii; Councilors: T. Au, D. Canete, P. Chinn, W. Dang, Jr., P. DeMare, C. Kelley, J. Betwee, P. Kim, C. Kadooka; Past Presidents: W. Chang, W. Dang, J. Lumeng, J. McDonnell, S. Wallach, Young Physicians Delegate: C. Goto.

Guests: Gladys Yamashiro - AETNA™ Medicare, and Walter Shim, M.D., Honolulu Symphony.


Minutes: The minutes of the July 13 meeting were approved as corrected.
- Dr Lehman introduced Gladys Yamashiro who informed Council that the Aetna™ Executive committee announced their withdrawal from the Medicare program throughout the U.S. as of October 1997. Aetna™ will continue to service claims during the transition period which will take about 6 months. A letter will be sent to Ms. Elizabeth Abbott, Regional Administrator of HCFA, Bruce Vladeck Jr., Administrator of HCFA and Robert Bath, Pacific Area Representative of HCFA expressing concern for retention of a local office.
- Dr Lehman reported: 1) The HMA Executive Officers met with HMAS who reported that they are planning to revise the participating physicians agreement and administrative operating procedures by October 1996. HMA legal counsel will keep the council abreast of the developments. 2) Mr Bruce Balle, AMA’s Strategic Planner, will come to Hawaii to do a strategic planning session. A cross section of physicians along with the Officers will attend the session. 3) A seminar will be held on No-Fault and Worker’s Compensation. HMA Officers and Mr Won interviewed a person who was interested in recruiting members for the HMA but felt the person was not suitable for the position. 5) The Hawaii Health Council will sponsor a meeting addressing alternative dispute resolutions in November for HMA members as well as other health care workers. 6) September is declared Women’s Health Month and the Hawaii Medical Journal is preparing a special issue addressing women’s health and domestic violence. 7) Annual reports are due by August 26, 1996 and Resolutions by September 17, 1996. 8) He continues to meet with an adhoc committee regarding a single point of entry in long term and disability care. A report is planned for the end of this year.

For Action
1) Council approved Dr Walter Shim’s request of Dr Sam Wong becoming an honorary member of the HMA, given no objection by the HCMS Membership Committee.
2) Council voted to work with any credible organization who proposes to become the EQRO for the Hawaii QUEST program.

Component Society Reports

Hawaii.—Dr P. Blanchette reported: 1) the HCMS is having a series of meetings at hospitals where nonmembers are invited. They will discuss Peer Review and how complaints are handled with a legislative update on what is current and what is likely to come up at the next legislative session.

Kauai.—Dr P. Kim reported the next county meeting will be on Saturday, September 7th. The members of the Kauai County are willing to help the HMA in any aspects necessary for the HMA Annual Meeting on Kauai.

West Hawaii.—Dr T. Smith reported: 1) That their County will have a joint East-West meeting. 2) The County is waiting to see what kind of action will stem from the AMA Federation Reorganization Report.

Hawaii.—Dr E. Bade reported that the last County meeting was July 25 with 40 physicians in attendance with speakers, Dr John Heaster who spoke on depression and Dr Bade who spoke on tuberculosis. The County also had a family picnic which was well attended.

Maui.—Dr M. Joshi reported: 1) That their County met a couple of weeks ago with a speaker who wrote a few books on alternative medicine. 2) With the new changes in Worker’s Compensation there are independent provider organizations being set up.

For Information

Credential Information Verification Service (CIVS): Mr. Won reported that marketing packets have been sent out to hospitals and organizations.

Urban Institute.—Representatives from the institute will attend an August 6 meeting at the HMA to hear comments from physicians on the QUEST program.

Patient Right to Know Act 1995.—Mr. Won reported that there are coalitions on the mainland whose purpose is to foster the idea that patients in managed care plans have the right or need to know in writing what benefits are covered and what is not covered. HMA will meet with coalition representatives in September.

Tobacco Task Force.—The Tobacco Task Force and HMA Officers met with Michael Fiore, a professor who just finished compiling clinical practice guidelines for the Dept. of Health and Human Services. A compendium of different literature which is available to physicians at no cost. The Task Force will seek to have the compendium available for physicians at the HMA Annual Meeting on Kauai in October.

AMA Delegates Report.—The AMA Speakers Report provided the highlights of the meeting. The Hawaii delegation’s resolution on tobacco was one of the highlights listed. Council gave Dr John McDonnell a round of applause for his dedicated work on the Tobacco Task Force and providing a well received resolution. Drs Calvin Kam, Russell Stodd and Allan Kunimoto also received a round of applause for representing the Hawaii Delegation at the AMA meeting.

Meeting was adjourned at 7:47 p.m.
We have over 200 specialists who can immediately turn to one another for assistance. But we’re not here just for each other. Straub would like to be a valuable resource to other physicians in Hawaii as well. Many of our specialists regularly visit the neighbor islands and are available for consultations.

We respect the relationship you have with your patient, which means we work closely with you to meet your needs and then return your patient to your care as soon as possible.

If you’d like consultation on a case, just call us at one of the numbers listed on the left. Or, if you’d like to talk to us about providing your services at our hospital or at one of our 11 clinics, please call Dr. John Berthiaume, Vice President, Professional Affairs, at 522-3973.

Give us a call today. After all, we’re here to help you help your patients.
A Doctor's Advice on Choosing How to Die

by A.A. Smyser

Reprinted from the Star-Bulletin 3/12/95, Hawaii's World

Editor's Note—September 1996
We continue the A.A. "Bud" Smyser "Hawaii's World" Honolulu Star-Bulletin columns. Dr Max Botticelli's presentation is reviewed in this March 12, 1996 issue of the Star-Bulletin, and is reproduced with permission. The Hemlock Hawaii Society can be contacted at (808) 735-7146.

What would you think of a physician who told you—that particularly in our later years, say 65 or over—you should:

- Consider how you want your life extended at all costs your last year likely will be filled with expensive and futile treatments.
- Be aware of the well-intended preachments of the American Cancer Society and the American Heart Association implying life is worth extending at all costs. Know that a "successful outcome" such as a reduction in tumor size does not necessarily promise a longer and better life.
- Choose treatments for whether they will make your life better. Learn the odds on a successful outcome. Ask your physician to describe the natural history or progression of your disease. Only then choose between treatment and simply being kept comfortable.
- Be aware that sanctity-of-life preachments may lead to excessive, futile, expensive end-of-life treatments.
- Consider a heart attack as a preferred way to die, as he does. If so, and if your life expectancy is not long, stop worrying about your high cholesterol. It is a main cause of heart attacks. He says high blood pressure on the other hand is a main cause of strokes, which are another matter.
- Be wary of aggressive physicians who for varying reasons, some crassly financial, will push you toward treatments at all costs. Unfortunately they don't come with labels on their foreheads, he says, but a trusted personal physician who understands your wishes can guide you away from their unnecessary treatments.
- Refrain from calling—or letting your friends call—911 if you want to be allowed to die. If anyone, call your personal physician.
- Be aware that simply having a living will is not enough. Through a power of attorney you should designate people to help aggressively enforce it for you.

Be sure your wishes are thoroughly understood by your agents, family and personal physician, in part to relieve them of any feeling of guilt from promoting your demise.

What would I do with such a physician? I'd love him, heed him, and spread the word about him as I am doing here.

He is Dr Max Botticelli, 64, recently retired as chairman of the John A. Burns School of Medicine at the University of Hawaii. He is one of a handful of socially conscious physicians in Hawaii who are working to make dying a peaceful, even welcome, event. Next to birth it is the most significant religious experience in life, he says.

He urges us to accept death's inevitability and plan for its as we plan for other events in our lives.

It was a joint meeting of Hemlock Hawaii and the Memorial Society of Hawaii. Some 300 people attended, most of them gray-haired.

He told them he has little faith in working for legislation to improve things. Rather, he would work ever harder to change public opinion. The Hemlock Society and Memorial Society, he said, should be as aggressive in promoting their message as the cancer and heart associations are in promoting theirs.

Men’s March Against Violence

Thursday, October 10

Educating for Non-Violence

This October 10, 1996, Honolulu will celebrate its 2nd Annual Men's March Against Violence. Once again hundreds of men will march and rally in downtown Honolulu led by civic and educational leaders. We are expecting more than 500 men marching and 300 women lining the route and joining them at the rally. This year's theme is Educating for Non-Violence. It is time for men to stand up and take a stand against violence in our homes, schools and community. It is time for each of us to break the silence and begin educating our children, our brothers and sisters, our fellow workers, and our leaders about non-violence. Join us!

While this is a march for men who wish to make a significant and courageous statement against violence, women are encouraged to support the marchers on the route, and attend the rally. For women who feel strongly about participating on a more profound level, please contact the YWCA Honolulu at 538-7061 and ask for information about the entire week which is filled with various events to bring Domestic Violence to an end. For regular updates contact Joe Bloom at 536-1794, or by fax: 599-8761. Leave your name, organization and fax number.
Keeping the Care in Managed Care

Managed Care is changing the face of medicine in many different ways. Through new ideas and innovative approaches, health care providers have a unique opportunity to shape the future of medical care in this rapidly changing environment.

For 10 years, the HMSA Foundation has helped providers face the challenges of an evolving health care marketplace through relevant educational programs. This year, we’re proud to join the University of California, San Diego, in presenting “Shaping Managed Care,” an enlightening two-day conference featuring managed care vanguards Dr. Robert Brook, Russell Coile and others.

Ilikai Hotel Nikko Waikiki
8:30 a.m. to 3:30 p.m.
Friday and Saturday, Sept. 27 and 28, 1996

Attendees will learn:
• Best practices from leaders in health care
• Cutting edge management practices that work
• Changing practice roles in managed care
• Local initiatives in medical management

And much more.

We look forward to seeing you at this special event. To register, call 1 (800) 711-5030. For more information about the HMSA Foundation, please call 948-5613.

“Shaping Managed Care” is co-sponsored by HMSA, Kaiser Permanente, Kapiolani Health, Kuakini Health System, Queen’s Health Systems, St. Francis Health Care Systems and Straub Clinic and Hospital.
News and Notes  Henry N. Yokoyama MD

Life in These Parts

A grateful Young K. Paik, director of Hawaii Bone Marrow Donor Registry wrote: “On behalf of the Registry, the St. Francis Medical Center and all patients, present and future, in need of a bone marrow donor, I would like to express our profound gratitude to the volunteers, the media and the 30,574 people of Hawaii who registered with us during the past month.”

Kaiser Medical Center launched a Diabetic Limb Treatment Program in January 1995 to prevent limb amputations among its 8,000 identified diabetics. The program was staffed by vascular surgeon Peter Schneider, internist Mitchell Motooka, orthoped Mark Santi and podiatrist Earl Wong. Comparison of 1993 and 1995 results were remarkable: Amputations dropped 56% (52 to 23 cases); hospital admissions dropped 16% (159 to 134 admissions) and hospital days dropped 65% (2,843 days to 995 days).

Miscellany

A car skidded on wet pavement and struck a light pole. Several bystanders ran over to help. A woman was first to reach the victim, but a man rushed in. He pushed her back and barked, “Step aside, lady. I’ve had a course in first aid.”

The woman watched his procedures for a few minutes and then tapped him on the shoulder, “Pardon me, but when you get to the part about calling a doctor,” she said, “I’m right here.”

From Playboy’s Party Jokes July 1996

A young physician would drop into a bar after office hours to order a daiquiri cocktail with nutmeg sprinkled over it. One evening the bartender discovered he was out of nutmeg, but he had a bowl of mixed nuts on the back bar. He grated a hickory nut over the daiquiri and served it to the doctor.

After a sip, the doctor asked, “What’s this?”

“A hickory daiquiri, doc,” was the reply.

From Laughter—The Best Medicine

The 30-year-old grand mulipar had just given birth in the northern Ontario hospital. She was being gently persuaded by my colleague to consider sterilization. “You’ve had ten beautiful babies,” he reasoned. “Don’t you think you should have your tubes tied?”

Her response was quick and to the point. “It’s a bit permanent, isn’t it?”


Discrimination

I had finished my OB-Gyn training and had just opened my office. An elderly gentleman walked into my office and requested an appointment to see me. My secretary politely declined the request saying I was a “woman’s doctor.” After further attempts on his part, she finally said, “I’m sorry, but the doctor only sees women.”

Indignant, he replied, “Is that legal?”

Stitches, June 1996

Michael Green, Cogowg, Ont.

Appointed

John Edwards Jr., QMC VP for physician relations was appointed president of Diagnostic Laboratory Service Inc. (owned 90% by QMC and 10% by KMC)

Brian Martin was elected president of Mental Health Association in Hawaii. Neal Winn was promoted to VP of Medical Affairs, Kapiolani Health, holding company for Kapiolani Medical Center for Women & Children. John Morris was named president & chief executive officer of Queen’s Managed Care Plans. Marek Mirski, former assistant professor in Neurology at John Hopkins was appointed director of QMC Neuroscience Institute.

Sportsmen

Veteran kendoist, Noboru Akagi (7th dan) will head a Hawaii physician delegation to participate in the All Japan Physician Kendo Tournament in Okinawa, September 21 to 23. The Hawaii team includes Steve Wilson (3rd dan), Michael Kurosawa (2nd dan) Warren Ishida (1st dan) and Junichi Tokeshi (1st dan).

Girth Control

In my early years of practice, amphetamines were widely used as appetite suppressants. A 40-year-old man who’d come for a different reason turned as he was leaving the consulting room and asked, “Say, Doc, could you give me some of them appetite pills?”

I was desperately busy, so I simply wrote a prescription for 30 once daily amphetamines and admonished him to be sure to return in one month so we could follow his weight loss.

He dutifully returned. Noting that his weight was down only half a pound, I said, “I guess those pills didn’t work well for you.”

He replied, “No, I guess not. Doc. But you know, it’s a funny thing—since I started them pills, I just had to force myself to eat as much as I used to.”

Condensed from Stitches J.E. Columbia, Saskatoon

Researchers Report

Researchers reported in the Archives of Internal Medicine that Dutchmen who drank black tea and ate apples had a 73% lower risk of stroke. A 15 year study of 552 Dutchmen showed that high flavonoid intake had an antiplatelet aggregation effect as well as an antioxidant effect.

A Harvard Medical School researcher Ichiro Kawachi reported in the Archives that women who drank coffee were less prone to commit suicide. The study included 86,626 female nurses from 1980 to 1990. There were 11 suicides among those who drank 2 to 3 cups of coffee and 21 among those who almost never drank coffee. The report is consistent with a 1993 Kaiser report of 128,934 men and women who showed a lower suicide risk among those drinking more coffee.

Researchers at University of Michigan Medical School led by a Sevon Kaug reported in the Archives of Dermatology that Retin-A rubbed daily for six months on stretch marks from pregnancy or obesity shrank the stretch marks 14% lengthwise and 8% in width in 10 patients (ages 17 to 32).

A study published in the JAMA and conducted by Medical College of Wisconsin researchers on 13 young, fit volunteers revealed that the treadmill burn 700 calories an hour, the stair machine 627 calories, the rower 606 calories, the cross-country ski machine 595 calories, the Airdyne 509 calories and a regular stationary bike 498 calories.

Indicator

Recently, when doing a preop assessment of a patient scheduled for mastectomy, I noticed rather prominent and somewhat pulsating neck veins. The patient hadn’t noticed them, so I asked her husband who was in the room, if he had noticed them. He blushed and said rather hesitantly, that yes, he had on many occasions while in bed. He used them as an indicator as to how he was performing.

Eric Paetkau, Ontario

Potpourri

Signs you need a new doctor

• You can read his handwriting
• His malpractice attorney named him Client of the Year
• He asks you to turn your head and cough during an eye exam
• During surgery he keeps repeating, “The thigh bone’s connected to the knee bone.”

Laughter, The Best Medicine Readers Digest August 1996

Conference Notes

Visiting Professor Lawrence Tierney

Iatrogenic Disease

Iatrogenic: “Induced by a physician”

Hipocrates said: “No no harm. Iatrogenic illness are as old as the practice of medicine” Moses called them “Diseases of medical progress.”

Clinical Expressions of Iatrogenic Illness

• Direct bodily harm related to diagnosis, invasive therapeutics, or supportive procedures, surgery, newer medical therapies
• Organ specific or systemic insult from drug therapy (dose related, idiosyncratic, interactive, expected effect).
• New disease as an indirect consequence of previous therapy
• Expression of natural history of diseases
• Insult unrelated to process of care giving (eg. falling out of bed)

Etologies of Iatrogenic Illness

• Bad luck ie, Murphy’s Law
• Problems with history, esp labeling
• Ill conceived or eccentric use of diagnostic tests
• Gaps in diagnostic synthesis
Therapeutic misadventure; remember surgery has self-recognized, 100% incidence of iatrogenic injury.
Assumption of innocuous nature of care process
Novel biomedical events
Sociologic phenomena

Several Causes of Iatrogeny
Stringent requirements of training with resultant lack of experience
Managed care
Diffusion of responsibility
Stress and fatigue
Archaic society favoring action over observation for coin toss situations
Revered system resulting in high esteem tendered to journal jockeys. ER “rocks”
Medicine as apprenticeship... “See one, do one, teach one” technique as an end

What Can we do?
More scrupulous attention to what we do
Be more attentive to rewards system eg. fundamentals and deemphasize technical procedures
Guidelines: Any procedure which can be taught within 72 hrs. Be skeptical about new procedures eg. streptokinase, tPA etc.
Recognize that we make mistakes eg. isoniazide hepatitis

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Hawaii Medical Journal Foundation

The Hawaii Medical Association Community Research Bureau, a 501 (c) (3) organization, has been established to support educational and scientific projects such as the Hawaii Medical Journal. All contributions are tax deductible.

If you would like to support the Hawaii Medical Journal, please send contributions to the Hawaii Medical Association, 1360 S. Beretania Street, Second Floor, Honolulu, Hawaii 96814. Please make check payable to the HMA Community Research Bureau/HMJ. Thank you for your continued support.

We are always looking for interesting scientific articles. To submit a manuscript, please call us for manuscript guidelines.

We also are starting a new Business card Directory page in the back of the HMJ with the classified ads. You now can submit your business card to advertise in the Journal each month. Each card is $100 a month or $1,100 a year. For inquiries and/or business card submissions, please contact the Communications Secretary at (808) 536-7702.

Hawaii Medical Journal Foundation

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Program Director
Beth Kurren ACSW, LSW
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  • Information & Referral

- Abuse Shelters for Victims & their Children
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  Hilo 959-8864

- Victim Support Groups
  Developing Options to Violence
  Oahu 532-5100
  Maui 877-6888
  Leeward Outreach Program 681-5903

- Batterer's Groups
  Developing Options to Violence
  Oahu 532-5100
  Maui 877-6888

- Anger Management (Men and Women)
  Developing Options to Violence
  Oahu 532-5100
  Maui 877-6888

- Transitional Housing 532-5100
A happy ending is our goal.

Everyone loves a happy ending. However, sometimes life presents us with challenges that require the assistance of professionals.

Kapi‘olani Health’s community outreach programs such as the Hawaii Family Stress Center (947-5700), Sex Abuse Treatment Center (524-7273), and Kapi‘olani Child Protection Center (944-9940), are committed to helping people strive for healthy beginnings — through intervention, counseling, education and prevention. These programs have assisted thousands of people in Hawaii.
AlohaCare has launched a Hawaii-based pilot program to identify mental disorders quickly and easily in primary care offices. The program employs a simple diagnostic tool called PRIME MD.

Rio Banner, MD, medical director of AlohaCare, said three groups—Kalihi-Palama Health Center, the Ohana Physicians Group and Mililani Family Practice—will take part in the evaluation. Other primary care physicians will be added if the pilot proves successful.

The tool has two main components, a set of questions the patient answers and a Clinician Evaluation Guide which the physician uses to ask follow up questions.

Streamlined assessment

Through these uncomplicated pieces, a primary care physician can assess a patient for
- depression
- anxiety
- alcoholism
- eating disorders
- somatoform disorders

PRIME MD was developed with the practicing physician in mind. The time requirements are minimal—it takes the physician only a few moments to go through the patient interview form.

"The payoff for the patient is an earlier diagnosis and treatment. The payoff for the physician and for AlohaCare is a healthier patient-client population at a lower cost," said John McComas, executive director of AlohaCare.

AlohaCare provides health care coverage statewide, principally to clients of the state's Med-Quest program.

Reported in JAMA

Patients with undiagnosed mental disorders, even threshold or mild ones, "have significantly impaired functions and greater health care utilization," according to an article in the Journal of the American Medical Association (JAMA), which reported on the PRIME MD program. It's one of those things that sounds too good to be true. Yet numerous studies have scrutinized the program and the results point in the same direction.

Identify those disorders, get them treated, and health care use goes down.

N. Lee-Smith, MD, an internist who's head of a stress medicine clinic and an associate professor of medicine at the University of Utah School of Medicine, told AlohaCare providers that the amount of care required in outpatient and inpatient facilities drops substantially—ine-patient utilization decreased by 73 percent in one study, he said.

The researchers who reported in the JAMA article said to their knowledge, PRIME MD is the first psychiatric diagnostic interview program developed for primary care physicians.

AlohaCare managers reviewed the literature and evaluated the protocol. Working with FPM Behavioral Health, which handles behavioral health services for AlohaCare, Banner set up the criteria for the pilot.

The JAMA article reported that "more patients with mental disorders are cared for in the primary care sector than in the mental health sector." Yet, the article continued, primary care physicians often fail to diagnosis mental disorders. The PRIME MD protocol was developed to help the physician recognize the disorder.

The JAMA article cited is: "Utility of a New Procedure for Diagnosing Mental Disorders in Primary Care," Spitzer et. al, December 14, 1994, Vol 272, No 22, P 1749+

Physicians interested in more information on AlohaCare's plans should contact Dr. Banner at 973-1650.
Hawai‘i Medical Association
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( Hawaiian symbol representing life. )
Nothing ever works out but sometimes something else does.

For years walk-in patients have had “eye exams” at department stores, e.g. Sears. Now two Illinois hospitals have opened a breast cancer screening center in a Skokie Nordstrom department store which takes both walk-ins and appointment patients. If there is a wait, the lady is given a beeper so that she can shop around until called. The X-rays are taken by mammography techs, interpreted by hospital radiologists, and the results forwarded to the patient’s personal physician.

He is like the rooster who thinks the sun rises to hear him crow.

Senator Edward Kennedy of Massachusetts was effectively blocking the health reform bill before Congress, but he has now given in. His primary opposition was that he did not want to allow medical savings accounts. The reason is not that he feared they will fail, but rather that he is certain they will work, both to control costs and to allow choice. It is a fact that the success of MSAs will surely reduce the possibility of an eventual federal takeover of the entire health care system. Since that takeover has always been Teddy’s goal, he placed his ever-enlarging bulk in the way. What a guy; he works so hard to protect the poor in America, to insure that they will always be there.

I don’t suffer from insanity; I enjoy every minute of it.

If you still labor under the delusion that we live in a sane world, not that in Los Angeles, surgeons at Cosmetic Surgery International perform 30 to 45 penile enlargements each week, and are booked a month ahead. Some surgeons, plagued by managed care and reduced incomes, see penile enlargement as a great money maker. Free from regulation, the operation to lengthen and/or widen the penis is offered with ads and brochures to appeal to men with a poor self image, or to use the old phrase, an inferiority complex. The American Urological Association and the American Society for Aesthetic Plastic Surgery claim that the “surgery has not been shown to be safe or efficacious,” but it is now big business (careful, not too big). Some recent testimonials, “This is absolutely the best thing that ever happened to me,” and “now when I go into business meetings, I’m thinking, ‘if you guys had just half of what I have,’” and “I can’t believe I waited so long.” However, the malpractice attorneys are enraptered, as the complaints pile up; infection, scarring, impotence, and incontinence. I wonder what you would call an attorney who specializes in this area of litigation?

Habit is habit and not to be flung out the window by any (wo)man.

Poor Hillary! Not only is she accused of wading around in Whitewater (but she forgot that), and trashing the White House travel office staff (shoe doesn’t even go), but her recent pre-election boo, “It Takes a Village and Other Lessons Children Teach us,” has come under criticism. It seems that her ghost writer, Barbara Feinman, received $120,000 paid by the publisher, Simon and Schuster, and critics say that amounts to a gift to the first family. Moreover, Ms. Feinman received no credit or acknowledgment in the book, and had to sign a confidentiality agreement. It remains a fact: dress her up, fix her hair, anoint her the first lady, and have her converse with Eleanor Roosevelt, but a lawyer is always a lawyer.

It is always with the best intentions that the worst work is done.

An unprecedented criminal action in Florida was brought with the arrest of a medical director of an HMO who was not licensed to practice medicine in that state. Although he is board certified in family practice and holds a medical license in Wisconsin and Indiana, the doctor is being prosecuted for practicing without a license in Florida. He apparently crossed the line beyond administration by making recommendations and decisions for care. The attorney for the Florida Medical Association stated that making recommendations for care is interfering in the doctor-patient relationship, and that is practicing medicine. If HMO medical directors are not licensed, there is no way to regulate them, and they are accountable to no one but the stockholders, according to a FMA spokesman. Ah, yes, managed care—good for investors, not so good for doctors or patients.

Gatekeepers provide excellent care, if you are not too sick.

An interesting study involving 221,000 patients at Duke University Medical Center suggests that patients arriving in the emergency room with chest pains, and diagnosed as having myocardial infarctions, were at greater risk in gatekeeper medical plans. Of those patients who were immediately turned over to cardiologists, 31% died within a year, while 38% of those cared for by internists died, and general physicians lost 40.3% of similar patients within one year.

I live every day as if it were my last, which is why I sleep on a bedpan with a tube up my nose. (Bill Maher)

While there appears to be strong public support for physician-assisted suicide, a recent study in the Lancet found that cancer patients wanted relief from pain, but did not seek suicide. Moreover, when queried about assisted suicide for reasons other than pain, support plummeted. Researchers found that depressed cancer patients were those most likely to request the service, irrespective of pain. The study appears to show a conflict, and rushing to make physician assisted suicide a constitutional right, may not serve those for whom the issue is supposedly directed. Additionally, those patients with terminal cancer were less trusting of those doctors who discussed suicide as an alternative.

What the government gives, it must first take away.

In 1975, the Pennsylvania legislature passed a law providing for a professional liability catastrophe loss fund, and in 1995 the state run program had record payments of $280 million. This fund is supported entirely by surcharges on a “pay as you go” basis; in other words, a bottomless treasure for malpractice attorneys. About 250 health care providers have refused to pay their portion of the $107 million surcharge, saying this process is crushing them financially. Those physicians who chose not to comply are facing disciplinary action, and the licensing board is required by law to suspend or revoke their licenses. Lucky you live Hawaii!

Aloha and keep the faith—rts.
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