A notable problem within studies of abuse is the lack of a clear definition concerning what actually constitutes abuse. Domestic violence (DV) is a type of abuse by a caregiver, parent, or spouse. It can take many forms. The American College of Emergency Physicians defines DV as “a part of a pattern of coercive behavior which an individual uses to establish and maintain power and control over another with whom he or she has had an intimate, romantic, or spousal relationship.”

The physical aspects of DV are well documented and can include sexual abuse, punching, hitting, biting, kicking, and stalking. These behaviors can be both real and threatened and with or without a weapon. Non-physical abuses are just as devastating and more common. These behaviors can consist of actual or threatened psychological abuse, social isolation, deprivation, or intimidation resulting in the neglect of physical, emotional, or economic needs. Specific examples are name-calling; loss of income (stealing, preventing victim from working, causing victim to lose employment); isolation from family, friends, and support systems; inadequate or lack of access to medical or attendant care; withholding, tampering with, or mismanaging medication; overmedicating; withholding food; and threats of placement in a nursing home or institution. Often the individual does not recognize that she or he is a victim of abuse.

Types of DV include physical, psychological (verbal, nonverbal, and emotional), sexual, and financial abuse. Overlap may occur in classifying the types of abuse within individual cases. The divisions between these types of DV may be cloudy, but a strong differentiation exists between the forms of physical abuse and sexual abuse. Neglect is considered a separate category for some health professionals, whereas others include it under psychological or physical abuse. We felt that neglect warranted its own category as a type of abuse for this article and the REACH program of the Allegheny District Chapter of the National Multiple Sclerosis Society (NMSS).

Incidence

Although violence against women has been common in our society, a movement to expose and criminalize such acts has only existed since the 1960s. Until recently, many states had laws that allowed a man to beat his wife with a stick or switch provided it was no thicker than his thumb, hence the origin of the expression “rule of thumb.” Today, both physical and nonphysical abuse of women is recognized as epidemic. An estimat-
ed 8–12 million women in the United States are victims of abuse. The National Violence Against Women Survey found that almost 25% of women report rape or physical assault by a current or former intimate partner in their lifetime.3

DV is a social, economic, and public health care issue that has no cultural or socioeconomic boundaries. In every country where reliable, large-scale studies have been conducted, results demonstrate that between 10% and 70% of women report they have been physically abused by an intimate partner in their lifetime.4 Canadian research has documented that 51% of women experience at least one episode of violence after the age of 16 years.5 A 1999 Canadian survey reported that 11% of women who were married or in common-law unions had experienced physical violence by their intimate partner within the previous 5 years.6 In Australia, DV of women is the leading contributor to death, disability, and illness.7

Violence against women typically occurs in heterosexual relationships; 95% of the cases reported in the United States are perpetrated against women by men. However, evidence documents that DV occurs within same-sex relationships possibly at the same rate.1,8 Nationally, the rate of violence against men is 7.6%, according to the National Violence Against Women Survey; however, reports of violence against men by an intimate partner may be on the rise.3

Research on issues specific to abused women with disabilities is nearly nonexistent. The lack of information is problematic because the few studies completed to date indicate that women with disabilities experience violence and abuse at similar or higher rates than nondisabled women.9 The direct and indirect effects of abuse on their health and barriers to seeking help are unknown. In addition, information about the experiences of abuse that women with disabilities face across cultures, disability types, and locales is extremely limited.

In people with MS and other disabling diseases, discussion of any abuse needs to include relationships beyond those of domestic partners. Studies show that abuse occurs in other relationships, including parents, children, and caregivers. Only in recent years has documentation shown that women with disabilities experience abuse at similar or higher rates and for longer periods than women without disabilities. The increased rates are because these women experience abuse not only by significant others but also by attendants and health care providers.10 Women with disabilities identified abuse as the most important health issue they face.11

**Risk Factors**

The question has been raised by Young et al.10 as to whether disability may be a risk factor for DV. Known risk factors of abuse to women in the general population include economic dependency, low household income, low level of education (high school or less), unmarried or recently separated,12 history of mental health problems, and substance abuse.13 Also, pregnant women or women who have recently given birth may be at greater risk.14 Partners of abuse victims have higher rates of alcohol use and emotional dependency on the victim.15,16 In the United States, domestic violence is 2–4 times more likely to occur among law enforcement families than other families in the community.17

People who experience mental health or cognitive issues and may be unable to manage their disease and less able to engage in health-promoting behaviors are also vulnerable. According to Vest et al.,12 past studies intending to identify victims and risk factors may have been clouded by the methods used to identify the victims (through surveys or only particular health care settings), and all people should be considered potential victims.

**Effects**

In 2000 in the United States, 1247 women and 440 men were known to have been killed by a current or former intimate partner.18 Many of the murdered victims were chronically abused both physically and psychologically before their death. DV injuries are common causes of nonfatal injury to women in the United States; head, neck, musculoskeletal, and soft tissue injuries are typical forms of injury that need urgent care.19 Abuse is associated with a range of adverse physical health effects. Arthritis, migraines, visual impairment, sexually transmitted infections, chronic pelvic pain, peptic ulcers, irritable bowel disease, and other digestive problems occur at higher rates than in the nonabused population.20,21 Victims may have higher incidences of neuropsychiatric illnesses such as anxiety, sleep disorders, chronic pain syndromes, depression, chronic fatigue, and posttraumatic stress disorder.22 According to Constantino et al.23 and Kiecolt-Glaser et al.,24 lower T-cell function exists in abused women. T
cells play an important role in cell-mediated immunity, delayed hypersensitivity, and instructing the other cells (natural killer cells, B lymphocytes, etc.) to start and stop fighting foreign invasion.25

Many abuse-related health issues in the nondisabled population are well documented, but little is known about the detrimental health effects of abuse victims who are disabled. In people with MS who have been abused, minimal to no information has been recorded about the frequency or severity of symptoms that are present and relate to their abuse rather than their underlying disease process. In many instances, patient complaints may not be explainable based on clinical exams and diagnostic studies, yet the disease process may be blamed when no objective alternative explanations are available.

REACH Program

In 2006, the Allegheny District Chapter of NMSS developed a program for people with MS known as REACH. The objective of the program was to address the problems of DV through the following intervention and prevention activities: respite care, educational opportunities, awareness, change, and hope (REACH). Funding for this 2-year program was provided through a local foundation, and, because of the compelling results, it has been renewed for an additional 3 years. REACH was developed by the chapter as a result of the incidence of domestic violence uncovered during a home care project for women with MS known as the Home Gynecologic and Breast Care Program. During that 2-year program, 10% of the women receiving care in the home disclosed physical abuse within their current living situation. Some of the abusive events resulted in severe physical injury. The program director realized that the problem of DV within this community was significant and needed to be addressed. Since its inception, REACH has continually evolved into an innovative and successful model for assisting people with MS who have been abused.

Respite

Respite is an ongoing program offered by the chapter that includes in-home support, transportation, and emergency financial assistance. Under the grant, respite has been expanded to include safety relocation assistance. The prevailing request from abused people with MS was financial aid for safety relocation options, including the first month’s rent, security deposit, utility connection fees, reparation assistance, and moving expenses. The financial aid program for safety relocation has assisted about 30 people in the first 2 years of the grant.

Education

The education portion of this program included both formal and informal training. The training sessions were presented by a medical advocate with 20 years of community experience serving victims of DV. Formal education programs include the following: definition of the problem of domestic abuse, identification of those at risk, assessment, and intervention strategies. More than 8000 people have been directly or indirectly informed and educated though this program, including people with MS, health professionals, legislative and legal staff, and the staff of NMSS. The resources used to advertise the education portion included lectures, Webcasts, support-group meetings, newsletter articles, Spotlight on Safety, continuing medical education programs, and poster presentations.

Through the program, >500 of the 8000 educated participants received direct training by the medical advocate. A Webcast is available to all health professionals online through the University of Pittsburgh (mediasite.cidde.pitt.edu/mediasite; select Center for Multiple Sclerosis and then Identifying and Addressing Domestic Abuse).

Awareness

To raise awareness of abuse with both health professionals and MS patients, screenings for abuse were instituted in two large academic MS clinics located within the chapter. Indirect awareness training was further presented in the chapter’s quarterly newsletter, which is distributed to ~7500 people in a 26-county area. Each article, titled Spotlight on Safety, featured information on abuse, characteristics of abusers, a Rate Your Mate survey, community resources, and safety planning strategies. A half-page discussion on the topic of DV was included, along with other articles that focused on education and safety strategies. Posters and oral presentations regarding REACH were a part of national and international MS health professional meetings.

Change

Under the grant, change was brought about by offering information and support. The medical advocate assisted every abused person in devising a service
plan (based on the individual’s goals). Each service plan included a safety and emergency escape plan and referrals to local victim service agencies. As permitted, the medical advocate acted as a liaison between the abused person and the service agency. Crisis intervention assistance and empowerment counseling were also offered. Options included referrals to victim service agencies, health care professionals, counseling services, legal remedies, affordable housing, and law enforcement.

**Hope**

Hope was offered through continued interaction by chapter staff to assist in developing immediate, short-, or long-term goals to improve access to safe, violence-free options; provide tools to regain control and confidence; and encourage and maintain independent living for victims.

One other goal of the program is to demonstrate to others that steps can be taken to achieve a more peaceful situation. We plan to achieve this goal through stories of DV victims who have made successful changes and can offer peer support.

**Disclosure of DV through REACH**

By June 2007, 150 people had disclosed through the REACH program that they had experienced DV. Of those, 93% (139) were women. About 75% attended one of the MS clinics where the screening programs had been initiated. Admission of abuse took place either during an appointment or over the phone to the staff of the MS clinics. Of the 25% who did not disclose through their health care setting, 11 of 37 individuals disclosed experiences with abuse during support-group training meetings, where the medical advocate was present and available to provide education and safety planning. Other victims were referred by various health care professionals, self-referred, or referred through significant others. NMSS chapter staff also fielded calls by people with MS looking for information and by family and friends reporting a situation and looking for vehicles by which to provide assistance.

Table 1 highlights the perpetrators of DV for each case of disclosure, and Table 2 lists the type of DV experienced by those who disclosed, including mental, verbal, financial, sexual, and physical abuse and neglect. Interestingly, many of these people did not consider themselves victims of DV until implementation of the REACH program.

### Table 1. Types of domestic violence experienced by people with multiple sclerosis assisted by REACH program

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>n ((N = 150))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>150</td>
</tr>
<tr>
<td>Economic</td>
<td>40</td>
</tr>
<tr>
<td>Physical</td>
<td>47</td>
</tr>
<tr>
<td>Sexual</td>
<td>32</td>
</tr>
<tr>
<td>Neglect</td>
<td>11</td>
</tr>
</tbody>
</table>

Note: Some victims experienced >1 form of abuse.

### Table 2. Perpetrators of domestic violence on people with multiple sclerosis identified by REACH program

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>n ((N = 150))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current partner</td>
<td>64</td>
</tr>
<tr>
<td>Former intimate partner</td>
<td>39</td>
</tr>
<tr>
<td>Dating partner</td>
<td>18</td>
</tr>
<tr>
<td>Parent</td>
<td>8</td>
</tr>
<tr>
<td>Sibling</td>
<td>3</td>
</tr>
<tr>
<td>Adult child</td>
<td>15</td>
</tr>
<tr>
<td>Minor child</td>
<td>6</td>
</tr>
<tr>
<td>Healthcare worker</td>
<td>1</td>
</tr>
<tr>
<td>Attendant or care assistant</td>
<td>1</td>
</tr>
</tbody>
</table>
and the patient must be assured of privacy. Chart documentation must also be confidential so that the patient is protected from a perpetrator who may be paying for insurance coverage.  

Screenings may not occur during routine medical appointments because of the numerous needs of MS patients that physicians already struggle to meet during often-limited time allotted for patient visits. Also, neurologists may not have knowledge about or feel comfortable discussing DV and may not have the tools necessary to assist an abused patient. In such cases, screening assistance should be sought from nurses and other health care workers who are in contact with patients while providing other necessary care.  

Health care workers caring for people with MS and other disabilities should consider initiating a screening program, after an appropriate training session for all health care professionals in the setting so that they can best identify people who are in an abusive relationship or at risk for abuse or neglect. A comprehensive system of care focusing on increased patient safety is required on a patient’s disclosure form so that appropriate accessible community resources can be provided. Because little information is available in this area, findings should be quantified so that patterns and trends can be observed.  

Within our clinic and through REACH outreach programs, the medical advocate uses the following direct screening questions to assess safety within a patient’s environment:

1. What is the level of stress in your home?  
2. Do you have support at home?  
3. Do you feel safe in your home?  
4. Are you afraid to go home with your partner or caregiver?  
5. Has your partner (caregiver) threatened to harm, leave, or institutionalize you?  
6. Has your partner threatened to harm someone you know?  

Traditional assessment tools that focus on intimate partner physical or sexual abuse may not be sufficient for the range of abuse experienced by women with physical disabilities. McFarlane et al. 28 have developed and tested the Abuse Assessment Screen–Disability tool, which can be incorporated as part of the general assessment questionnaire used by health professionals in medical settings.  

Because so little information is available on DV involving people who have disabilities, information related to instances of abuse reported by all people with disabilities must be indentified and quantified on local, state, and national levels to effect substantial change. The medical advocate of REACH has been extremely successful in networking with and training legal professionals and members of the legislature while educating these groups and the victims. Identifying issues faced by people with MS on local, state, and national levels through advocacy and training will enable improved services and protection for people with MS.  

Although significant policy developments have emerged in the United States over the past 20 years, the reduction of abuse in relation to disability is still in its infancy. The Global Campaign for Violence Prevention 29 was launched after the release of the World Report on Violence and Health. 30 The objectives of the campaign are to raise awareness about the problem of violence, highlight the crucial role that public health can play in addressing its causes and consequences, and encourage action at every level of society.  

Often, DV victims report that they do not want to end their relationship; they just want to end the abuse. REACH revealed the same situation. Most abuse victims in the REACH program were emotionally, financially, physically, and cognitively dependent on the violent partner. Individualized plans and support systems were developed to maximize safety for the victims because most chose to remain in their relationship.  

**Summary**  

The REACH program has generated an overwhelmingly positive response from people with MS, health care professionals, state and federal legislators, members of the judiciary, and the community. The findings described in this article are proof that the program was needed and has been successful. However, REACH addressed immediate and short-term safety needs; long-term needs remain unidentified. The unpredictable nature of MS in cognitive, emotional, and physical capabilities commands more extensive intervention, assistance, follow-through, and long-term planning by the medical advocate to maintain independence and seek healthy, supportive networks. As this program continues to evolve and new needs and problems emerge, support services will continue to evolve and meet the needs of abused people with MS.
References


