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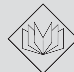
Intimate Partner Violence

A Resource for Professionals Working with Children and Families



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A Resource for Professionals
Working with Children and Families

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Foreword

Intimate partner violence (IPV) is as old as history. According to the Minnesota Center Against Violence and Abuse, the first recorded laws governing IPV date from 753 BCE during Romulus's reign over Rome.[1] The "Laws of Chastisement" condoned wife beating. The husband could use a switch or a rod as long as the diameter of the instrument was no greater than that of the base of the man's right thumb, which is the origin of the commonly used term "rule of thumb." The authority of the husband continued in Jewish and Christian traditions. The Roman Emperor Constantine the Great had his spouse burned alive, and England's King Henry VIII was known for violently disposing of inconvenient wives.

Even in current times, intimate partner violence continues to threaten family, physical, and mental health. In many Arab and Islamic countries, domestic abuse is considered a private "family matter" rather than a problem that should be addressed by the police and medical care providers. The reputation of the family is of utmost importance, and the involvement of outside agencies and authorities is not tolerated.[2] In Western countries, laws against spousal abuse are on the books, and as a culture, intimate partner violence is not tolerated. Even so, the Department of Justice reports that each year in the United States, women experience 4.8 million assaults and rapes by intimate partners and almost 1200 women are killed by their partners.[3,4] Men can be victims of intimate partner violence as well, although it is not reported as frequently as in women (2.9 million assaults and 800 deaths yearly).[3,5]

How can we tolerate this level of family violence, with the knowledge that it causes physical and mental pain, increases medical expenses, and triggers long-term psychological harm to children who witness these events? For health care providers in particular, Towervi has identified 3 major factors that prevent effective response to intimate partner violence: 1) health care professionals' lack of knowledge about IPV that leads to failure to identify abuse; 2) personal attitudes and beliefs held by health professionals that make it uneasy for them to address IPV with patients; and, 3) a lack of time, which inhibits caregivers from responding appropriately to IPV issues.[6]

This book, edited by Giardino and Giardino, addresses these 3 barriers to identifying and caring for victims of IPV. The book distills a large body of knowledge into a readable, useful, rich resource. It is well organized and carefully annotated. The information is both theoretical and practical. The book is a single source that can educate professionals, change attitudes, and save time by having all the necessary information readily available in a single resource. The book addresses another sensitive issue in the field of IPV: the unresolved tension between advocates for children and advocates for adult IPV victims. Should children be taken away from a battered woman who is unable to separate from the batterer? Is that considered blaming the victim or protecting the children who experience secondary trauma from witnessing the abuse? The book's title, *Intimate Partner Violence: A Resource for Professionals Working with Children and Families,* reflects the editors' awareness of the need for balance and consideration for parents as well as children.

Hopefully we, as a society, are gradually recovering from millennia of family violence and realizing that these problems can be confronted with multidisciplinary efforts by health care providers, mental health professionals, victims' advocates, and law enforcement.[7]

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FOREWORD

As a society, we have made significant strides to address victimization and perpetration caused by intimate partner violence (IPV) in the United States. Our approaches to addressing IPV were brought center stage in the early 1990s when the Violence Against Women Act (VAWA) 1994 became law. After significant inquiry into the extent and severity of domestic violence, sexual assault, and stalking, congress determined that there needed to be funds allocated to address the issues of intentional violence, as the problem in the US was pervasive and was having a detrimental impact on society.

This was to be a pivotal moment in the United States' history as it defined the values we choose to invest in as a nation. VAWA became a comprehensive legislative package that facilitated services for victims, strengthened local and federal laws, and promoted enforcement of protective orders. VAWA also created legal assistance for immigrants who were battered that prevented their abusers from using immigration law to control victims. The toll-free National Domestic Violence Hotline was also established through the passage of VAWA. Additionally, funds were appropriated to support battered women's shelters, DV and sexual assault education intervention, and prevention programs. The grant programs provided support to state, tribal, and local governments and community-based agencies to train staff, establish specialized domestic violence and sexual assault units, assist victims of violence, and hold perpetrators accountable. This nation could not have begun to address the depth of societal issues caused by IPV without VAWA. As I reflect on this history, I gratefully acknowledge the progress we have made while remaining equally mindful of the dire need to do more.

Much has been discovered about the effects of violence on individuals, families, and communities. It was the late Dr. Martin Luther King that summarized the effects of intentional violence so poignantly, by stating, "Violence is immoral because it thrives on hatred rather than love. Violence is impractical because it is a descending spiral ending in destruction of all. It is immoral because it seeks to humiliate the opponent rather than win his understanding; it seeks to annihilate rather than convert. Violence ends up defeating itself. It creates bitterness in the survivors and brutality in the destroyers."

Dr. King's words have resonated true in my professional experience over the past 20 years. As a nurse practitioner and sexual assault nurse examiner in a variety of clinical settings, I have repeatedly witnessed the devastating effects that intentional violence (such as IPV) has on women, children, and men. I believe that Dr. King would be proud of the progress made over the past two decades and he would, without a doubt, challenge us to do more. After all, the approaches used to address intentional violence are based on the values that we, as a society, choose to adopt. Understanding inflicted intentional violence begins with saying, "This is not right," and then asking, "What can be done?"

Intimate Partner Violence: A Resource for Professionals Working with Children and Families assists the reader in answering the latter question: "What can be done?" We now know and understand the dynamics of IPV and its effects. The literature related to IPV has grown exponentially and what sets this volume apart are its multiple interdisciplinary contributions. This book provides practical information that is needed to address intervention strategies that need to be employed in the various clinical settings. Integrating a number of disciplines in one book has great value. We have come to know and acknowledge that caring for victims of violent acts is best done is concert

and that learning from each other makes us more proficient in our respective disciplines. Each chapter is written by scholars who have earned the respect of those of us working in the domestic violence community. Compiling the knowledge of these authors collectively serves novice and experts well and comprises a book that can be used in a variety of clinical and educational settings. We know that no single discipline is capable of providing all the tenants of care needed on its own—but, together, we have the capability to assist victims and their families in healing and thriving in the aftermath of violence.

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FOREWORD

For the past 15 years, I have served as the director of an intervention program for young children affected by violence. The program partnered with the Boston Police Department and was created in response to the epidemic of community violence afflicting our city (and many urban areas) in the early 1990s. Our intention was to identify the hidden victims of crime—the youngest bystanders to street and gang violence—and to provide them with developmentally informed counseling to alleviate the pernicious effects of violence.

Our first referral was a four-year-old boy who had witnessed the shooting death of his mother. The police first thought it was a random shooting; this assumption turned out to be wrong. The woman was shot and killed by her boyfriend. This unfortunate event exemplified a trend that was clear by the end of our first year of offering services, a trend that has since remained the same: the vast majority of referrals we received were for children who had witnessed violence in the home, often between the adults who provided care for them, not violence among strangers on the street. This violence, the kind that occurs behind closed doors, was much less visible than community violence. We realized, also, that it was much easier to talk about the violence in our streets than to confront the violence within our homes.

In the years since then, domestic or intimate partner violence has become a more visible and public issue. There is now increasing social acceptance for women to come forward and disclose intimate partner violence, which has been called a national epidemic and a public health crisis. Professional medical societies have issued position papers and guidelines to their members about assessing for and responding to intimate partner violence. In 1994, federal legislation, the Violence Against Women Act, was enacted that provided funding in every state to support shelter and legal services for battered women and their children.

Concurrently, unprecedented advancements have been made in the research and knowledge base about the impact of trauma on children. A finding with particular relevance to this topic comes from an analysis provided by the National Child Traumatic Stress Network of children served by its network of programs. This survey investigated the various kinds of traumatic events that were in the case histories of children referred for mental health services. Forty-six percent of children had histories of intimate partner violence. Additionally, the average age of the child's first traumatic experience was age 5. There are now hundreds of studies that explore the range of adverse effects of children's exposure to intimate partner violence. The risks include emotional and behavioral problems, learning problems, difficulties with peer relationships, juvenile delinquency, adolescent substance abuse, and adverse health outcomes in adulthood. These links are especially strong if the exposure to violence occurs in early childhood—the time when young children are the most dependent on their adult caregivers for physical and psychological protection.

The encouraging news is that we now know more about how to help victims and perpetrators, and we know that early intervention with vulnerable children makes an important difference. The single most effective approach to intervention for children is to help their adult caregivers reestablish a safe environment. The increased recognition of the devastating legacy of intimate partner violence demands that we intervene early and that we redouble our efforts to identify adult victims and offer them services.

The health care system—both adult and pediatric health services—is a critical ally in the effort to identify and intervene with families affected by intimate partner violence. It is perhaps the one service system that encounters most adults and virtually all children at some point. For adults, their health care providers are a trusted and respected source of information and a critical link to services. Although health care providers sometimes worry that these questions are unnecessary or offensive to patients, our experience proves otherwise. For example, in a recent initiative to improve screening for intimate partner violence in the pediatric Emergency Department at Boston Medical Center, a large majority of parents have expressed approval—even appreciation—when being asked about relationship violence. In order to build our capacity to identify and respond to families who struggle with intimate partner violence, it is essential that health care providers have the opportunity to increase their understanding of the issue, their knowledge of resources and collaborators in the community, and their skills in discussing this issue with patients.

Thus, the value of this book, *Intimate Partner and Domestic Violence: A Resource for Professionals Working with Children and Families,* is evident. Written by a diverse group of health care professionals, the book includes social work and mental health professionals in its audience. It is comprehensive in scope, with a concise review of the literature on screening in health care settings, 2 chapters on working with male perpetrators, and a chapter on teen dating violence. The material includes research, epidemiological data, and concrete practice suggestions. This will be a useful and accessible resource for a range of professionals who work with families and it will help each of us to ensure that children and families remain safe.

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PREFACE

This book was specifically developed to meet the information and clinical practice needs for professionals who work with children and families to identify and initially respond to intimate partner violence (IPV). Parents, mostly mothers, who bring their children in for care are willing to answer questions on a whole host of issues that may impact their children's well being, including violence in their own households. As a society, we have learned the significant negative consequences that IPV can have for the children living in its shadow. Such consequences include the ongoing stress of living in an unstable, volatile home environment, the potential for the child to be physically maltreated, and the increasingly recognized psychological damage that comes from witnessing or being exposed to violence in the home where a loved one is threatened or harmed.

In 1988, two publications helped raise awareness of IPV's overlap with child maltreatment. Both Tjaden and Thoennes' *In Harm's Way: Domestic Violence and Child Maltreatment*[1] and the statement by the American Academy of Pediatrics' (AAP) Committee on Child Abuse and Neglect, entitled, "The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women,"[2] provided data and policy recommendations that made clear that intervening on behalf of the victimized intimate partner was also a way to reduce risk and decrease harmful exposure for children who lived in those violent households. The AAP clearly stated that intervening on behalf of the mother who was being harmed might very well be the most effective child abuse prevention program available. All that we have learned over the past decade has reinforced the wisdom of intervention and has prompted a great deal of professional interest while calling attention to the need for increased training and attention to the signs and symptoms of abuse in the clinical setting. Despite growing awareness, many opportunities are still missed to screen, identify, and respond to parents who are being harmed by their partners. Missed opportunities in both adult and pediatric settings are evidenced by the generally low screening rates and the paucity of effective office procedures and protocols around IPV screening and intervention.

Professionals in other health care settings who deal with children and families may find this book valuable to their professional practice. The authors have kept all health care professionals in mind when writing the various chapters contained herein. We see our audience as broad while directed at physicians, nurse practitioners, physicians assistants, nurses (office, emergency department, and school), and clinical social workers. We also think the information will be beneficial for teachers, child care workers, social service workers, attorneys, law enforcement personnel, judges, and others who consider themselves child advocates.

Long ago, those of us in the child abuse field learned that it takes a whole team of professionals, each with their own expertise and professional identity, to adequately deal with the problem of child maltreatment. The same is true for IPV—no one field or agency has all the tools to help those we seek to serve. Professionals must work together, share knowledge, and forge linkages between fields, agencies, and areas of professional practice. We are fortunate that early in our careers, we came across incredibly dedicated professionals and community activists in Philadelphia who came together to form the Institute for Safe Families. The mission of the Institute for Safe Families (www.instituteforsafefamilies.org) was singularly focused on increasing the awareness of and the community's response to both those who were at risk and those who were harmed by IPV. Being part of multiple training efforts, several community initiatives, and a number of public awareness campaigns showed us one thing—

professionals will do the right thing if empowered with up-to-date knowledge and the tools to respond effectively. We saw that adequately prepared professionals who were supported by well designed community resources were not limited by the age-old "fear of opening Pandora's box," but instead, would passionately seek to screen their patients in hopes of drawing the problem of IPV out of the shadows to prevent and eliminate the harm that IPV brings.

We hope this book contributes towards that shared mission of encouraging our professional colleagues to address this multifaceted public health issue in an informed and effective manner. We all dream about the day when books such of this will no longer be necessary, but in current times, IPV causes far too much harm for us to avoid directly confronting it in our clinical work. So, we offer this work to all who want to make a difference in the lives of children and their families. Clinicians diagnose what they know just as other professionals working to prevent and end IPV work within the context of their knowledge. This is the reason why, with this book as a desk reference, professionals will be enabled to properly and authoritatively screen, identify, and respond to IPV. Together as a committed team of professionals, we can identify this problem and make effective efforts towards mitigating the negative effects that IPV has on children and families.

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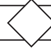

Intimate Partner Violence

A Resource for Professionals
Working with Children and Families

STM **Learning,** Inc.
St. Louis

Chapter 1

Overview of the Problem

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When conjuring an image of intimate partner violence (IPV), most people find themselves picturing the sad face of a woman covered with bruises. But the damage and long-term effects of IPV run deeper than the visible physical injuries to its victims. These victims may experience shame, isolation, detrimental physical and mental health consequences, and financial stressors. Intimate partner violence also has dramatic effects on the families of victims, especially children, who, in addition to the increased risk of physical abuse, may experience the trauma of witnessing the violence and feeling the fear, guilt, and shame associated with it.

Intimate partner violence is commonly defined as a pattern of coercive behaviors including repeated battering and injury, psychological abuse, sexual assault, progressive isolation, deprivation, and intimidation.[1–3] Although professional literature makes use of more specific terms, such as spousal abuse, wife-battering, and domestic violence, IPV is the most inclusive referent for this phenomenon. Intimate partner violence is a pattern of coercive behavior in which an individual establishes and maintains power and control over another with whom he or she has a relationship. Intimate partner violence as described above not only includes physical abuse, but also verbal, emotional, economic, and sexual victimization, and involves intimidation, threats, and isolation. Intimate partner violence crosses all socioeconomic and ethnic groups and occurs in both heterosexual and same-sex relationships. Because most IPV incidents are not reported to the police, it is believed that available data greatly underestimate the true magnitude of the problem.[4,5]

Intimate partner violence is appropriately seen as a public health priority, in that large numbers of the population are at risk for this form of victimization. As professional understanding of IPV has increased, screening tools have emerged for health care professionals to use during the health care encounter, and intervention strategies have been developed to help ensure the victim's safety and to enable them to leave the relationship. Additionally, batterer intervention programs have emerged with the goal of decreasing the risk that perpetrators will use violence in their relationships again.

This book is directed at health care professionals who may be the first nonfamily member a victim of domestic violence turns to for help.[1] Physicians, nurse practitioners, and other clinicians are frequently in a position to observe patterns of injury, repeated injuries, adverse mental outcomes, and other indicators of IPV, but may fail to recognize them as such. Initiatives around IPV screening in the health care setting initially studied adult providers such as emergency medicine, family practice, internal medicine, and obstetrics and gynecology (OB/GYN), but these initiatives have been disseminated to pediatrics and pediatric emergency medicine as well. While progress has

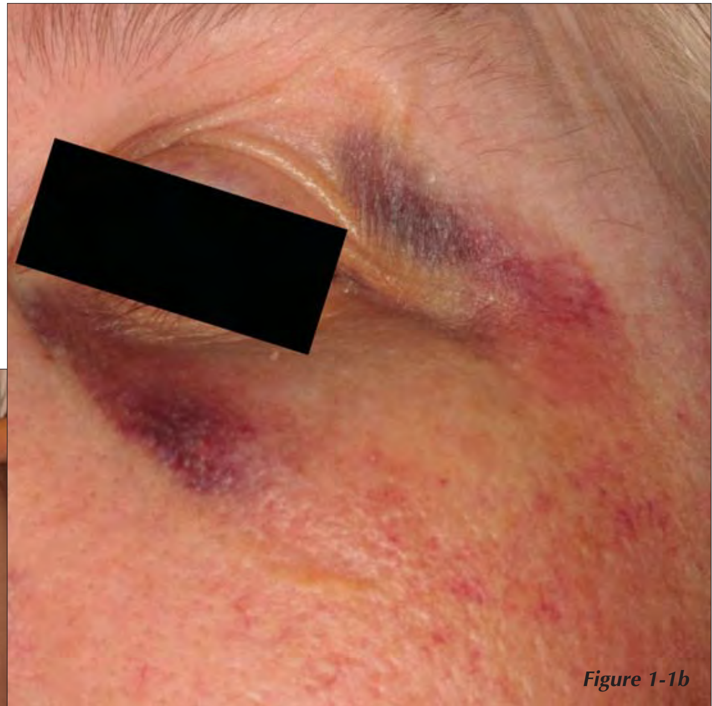
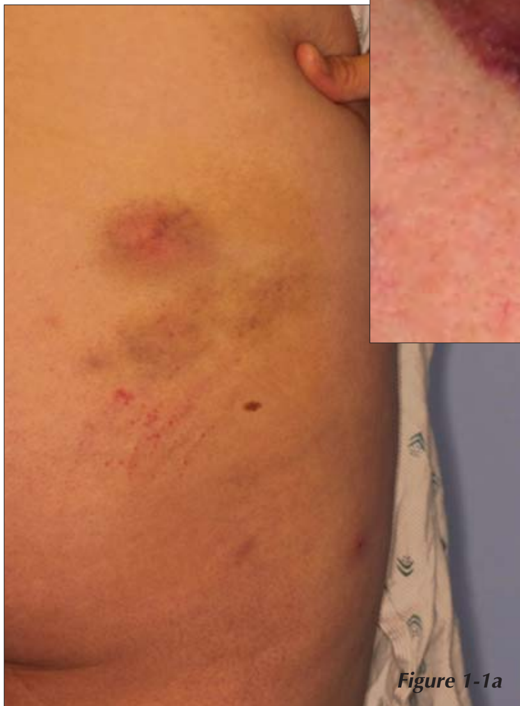


Figure 1-1b



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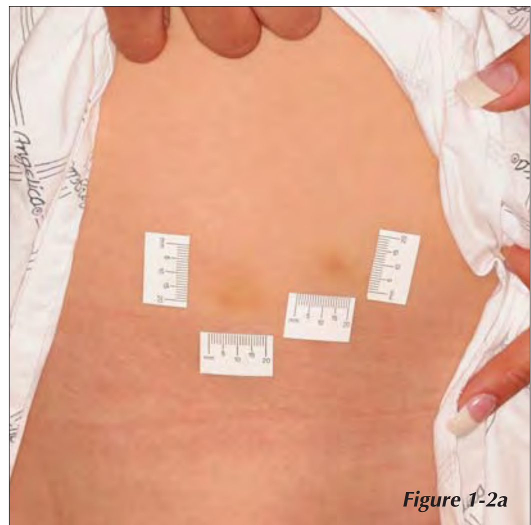


Figure 1-2a

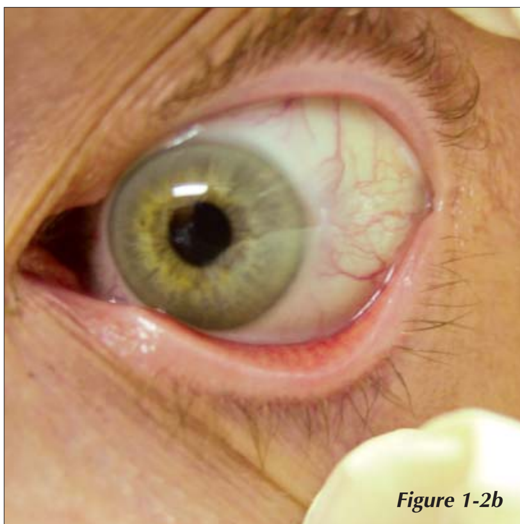


Figure 1-2b

Figure 1-1a and 1-1b. *Typical bruises resulting from physical violence.*

Figure 1-2a. *Fingertip sized bruises on the outer left thigh prove forceful grabbing as the victim attempted to flee. The bruises' yellowish hue indicates that they are not fresh.*

Figure 1-2b. *Upon restraining the victim, the batterer began strangling her despite the lack of petechial hemorrhages in the sclera of the eye.*

Chapter 2

Screening and Identification in Health Care Settings

JoAnn Mick, PhD, MBA, RN, AOCN, CNAA

Every year, health care professionals process millions of domestic violence victims through the medical system. Their knowledge and skills in providing care make these health care professionals well situated to identify such patient problems. In addition, health care professionals have unique opportunities to recognize and assess the various physical, sexual, and psychological injuries or other presenting symptoms caused by domestic violence. Routine screening assessments used to identify domestic violence can enable health care professionals to diagnose the situation, offer resources and support, and make referrals for assistance. However, many victims are seen and discharged by health care providers without identification of the occurrence of domestic violence and without offers for education or treatment to help these victims manage their situations.[1] Health care providers' failure to recognize or respond to a domestic violence problem often results in a patient's continued experience with violence, which may progress in severity and negatively impact the patient's health status.[2]

Definitions

Intimate Partner Violence

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as physical and sexual abuse, the threat of physical or sexual abuse, and/or emotional or psychological abuse (eg, humiliating the victim, controlling what the victim can and cannot do, isolating the victim from family and friends).[3] The person who is or was involved in an intimate relationship with the victim perpetrates these coercive behaviors.

Screening

Screening in health care refers to performing assessments, procedures, or tests that detect an illness early in an asymptomatic person.[4] With ***universal screening***, health care providers assess all patients; with ***selective screening***, health care providers only assess those patients who meet specific criteria (eg, injuries that suggest possible abuse; pregnancy associated with young age and low income; mental health problems, including depression, anxiety, and suicide attempts; alcohol or substance use; history of childhood sexual or physical abuse). Screening for intimate partner violence is described by Nelson and colleagues[5] as assessment in a health care setting for current harm or risk for harm in asymptomatic women or families who may be experiencing IPV.

Prevalence

Health care professionals currently practice routine screening for a number of common conditions in which the prevalence is less than or similar to that of domestic violence

(eg, cancer, blood pressure, risk-related behaviors). Intimate partner violence affects 1 of every 4 women in the United States. Men also are victims, but the prevalence is 1 in every 12 men, and the degree of injury is much lower. The lifetime prevalence of IPV in the United States is 7.6% for men and 22.1% for women; the 1-year prevalence of IPV in the United States is 0.9% in men and 1.5% in women. Intimate partner violence occurs in all socioeconomic categories, among all ethnic groups, and in both heterosexual and homosexual relationships. An estimated 3.3 to 10 million children witness IPV annually in the United States.[6] Universal screening provides critical opportunities for disclosure of domestic violence and allows patients and health care providers the chance to develop safety plans and improve health outcomes.

Health Consequences

Harmful outcomes of family violence include acute trauma, death, unwanted pregnancy, long-term physical problems, and psychiatric disorders (eg, depression, posttraumatic stress disorder, somatization, substance abuse, risk for suicide).[7-12] When victims at risk for or experiencing domestic violence are identified early, a provider can intervene and help patients understand their options and develop safety plans to remain in or leave the relationship.[1]

Health Consequences to Victims

Results of a qualitative study by Taft, Broom, and Legge[13] support that IPV affects the entire family, including the children. Repeated physical assaults or chronic psychological stress may increase risk of injury or chronic diseases for all family members. All IPV victims experience significant short-term and long-term psychological and physical health problems.[14]

Victims of IPV have higher self-reported, gastrointestinal symptoms (eg, eating disorders, chronic irritable bowel syndrome). They may also report cardiac symptoms (eg, hypertension, chest pain) or psychological conditions (eg, depression, suicidal tendencies, symptoms of posttraumatic stress disorder). Health consequences related to alcohol or drug abuse are also common outcomes of IPV.[15,16]

Health Consequences to Children

The American Academy of Pediatrics (AAP) recognizes IPV as a pediatric issue. If the mother is a victim of IPV, her children are also likely victims of the situation. Intimate partner violence can affect the emotions, self-perceptions, and social functioning of children, resulting in developmental delays and psychiatric disorders.[5] Intervening on behalf of victims may effectively prevent child abuse.[17]

Health Consequences of Childhood Exposure

Negative health outcomes found in adults are linked with childhood exposure to domestic violence, child abuse, sexual abuse, and family dysfunction (eg, a deceased parent, a parent with mental health problems, a parent who is in jail, a parent with substance abuse problems). Such health consequences can include unintended pregnancy, sexually transmitted diseases (STDs), alcohol abuse, smoking, suicide, depression, heart disease risk factors, chronic lung disease, and liver disease.[2,11,12,18]

Current Recommendations of Professional Organizations Regarding US Preventive Services

The American Nurses Association (ANA),[19] American Medical Association (AMA),[20] American Academy of Family Physicians (AAFP),[21] American College of Physicians (ACP),[22] and a number of other national health care organizations

Chapter 3

DATING VIOLENCE AMONG HIGH SCHOOL AND COLLEGE STUDENTS

Eileen R. Giardino, RN, MSN, PhD, MSN, FNP-BC

Dating violence is defined as psychological, sexual, or physical violence within a dating relationship.[1] Dating violence may occur at first meeting, during the dating relationship, and even after the dating relationship has ended. The definition of dating violence may vary to include physical violence only or physical violence along with emotional and psychological components of dating interactions as well. The implications of dating violence affect all aspects of the victim's health and well being. Health care providers must be aware of the problems associated with dating violence while knowing how to identify and treat victims in health care settings.

This chapter first addresses facts about dating violence among high school and college-aged people and then implications for practice of medical and mental health care providers. It is important for those who work with teenagers and young adults to know the prevalence of dating violence as well as the associated risk behaviors among those who report dating violence. The more providers know to ask about dating violence, the more likely one is to ask the right questions, make appropriate interventions, and reduce the likelihood of further victimization.

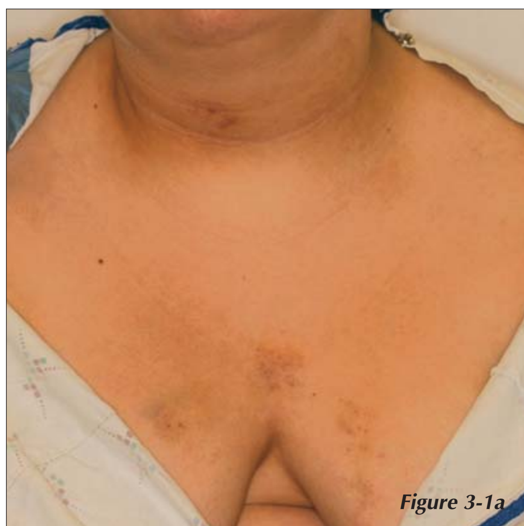
DATING VIOLENCE DEFINED

Dating violence occurs between people who are dating (both heterosexual and same-sex couples) and have or may move towards an intimate relationship, but does not apply to people who are living together without such a relationship. Dating violence is an effort to control the partner and involves a spectrum or pattern of behaviors that may include physical or psychological injury.[2]

There are many behaviors that comprise dating violence. One may experience a single incidence of violence, such as date rape or sexual assault. There may also be a repeated pattern of mistreatment or abusive behavior that escalates over time within a relationship. A perpetrator usually tries to exert power and control over their victim and may use a variety of tactics to exert that control. Patterns may include psychological abuse, physical injury, the threat of injury, progressive social isolation from friends and family, control over what someone wears, sexual assault, deprivation, stalking, threats, insults, intimidation, and even murder.[3,4]

TYPES OF DATING VIOLENCE

Table 3-1 shows behaviors that may exist in the different types of physical dating violence. The following descriptions of victimization provide examples of types of interactions and abusive acts that may occur in a dating relationship.[4,5]



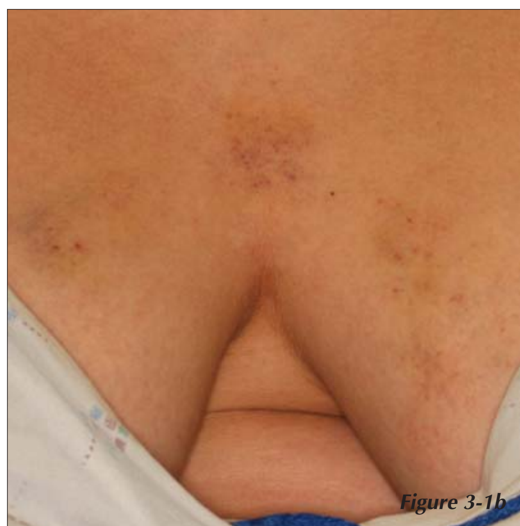


Figure 3-1a and 3-1b. *This victim's suck mark injuries to the right and left inner top breast area exemplify a common form of sexual violence.*

— ***Sexual violence.*** Includes all forms of sexual harassment, sexual coercion, or sexual assault. Sexual harassment is a pattern of unwelcome or unwanted sexual words, behavior, or actions. Sexual coercion involves manipulating a situation or person unfairly in order to get sex. Sexual assault includes any form of sexual activity without gaining the partner's consent.

— ***Psychological violence.*** Involves the use of words or actions to intimidate, isolate, or control someone. The intent of this form of victimization is to damage one's sense of integrity or self-worth.

Incidence and Prevalence

A high incidence of dating violence is reported by high school and college students ranging from 9% to 57%. However, differences in estimates of the incidence and prevalence of teen dating violence vary due to the ways in which researchers collect data about the problem.[6,7] Much of dating violence data comes from studies, rather than police reports, that ask respondents to report incidences of dating violence. The data has been collected in different ways and on different sample ages that may mix study populations of middle school, high school and college-aged students. Studies that estimate the rates of dating violence are often based on convenience samples among specific groups of people of different ages. Such samples usually limit the generalizability of the findings to broader populations.

A 2003 nationwide Youth Risk Behavior Survey (YRBS) of students in grades 9 through 12 asked one question regarding physical dating violence (PDV): "During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?" Of 14 956 students, 8.9% reported experiencing PDV. The prevalence of PDV victimization was similar for males (8.9%) and females (8.8%) and similar by grade level (range: 8.1%-10.1%) **[See Table 3-2]**. There was a higher reported prevalence of PDV victimization among blacks (13.9%) than whites (7.0%) and Hispanics (9.3%). The prevalence of PDV victimization was less among white males (6.6%) than black males (13.7%), and less among white females (7.5%) and Hispanic females (9.2%) than among black females (14.0%).[1]

The incidence of dating violence is widespread, with 85% to 90% of victims being female adolescents and adult women.[8] A study of women 14 to 26 years of age who visited a family planning clinic reported 43% experienced 1 or more episodes of

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AANP; *see* American Academy of Nurse Practitioners
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