Family violence: guidelines for recognition and management

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Chronic and intermittent abuse of one family member by another is common. Victims may be children who are sexually or physically abused, wives or live-in partners, or older relatives. Physicians are often the first points of contact for patients who have been abused, but the abuse is frequently concealed by the victims. Physicians should be alert to signs of battering such as bruises in various stages of healing, unusual behaviour in children and interpersonal difficulties in the family. There are a number of options in prevention and treatment, including referral to social service and legal authorities, calling on other resources in the family and helping the individual develop coping skills. This review also lists a large number of social agencies in Canada that are willing to help victims of abuse.

Les sévices répétés et de longue haleine au sein de la famille sont fréquents. La victime en est un enfant maltraité physiquement ou sexuellement, une épouse ou une concubine, ou un parent âgé. Elle s'adresse souvent en premier lieu au médecin, mais en lui cachant fréquemment qu'on l'a maltraitée. C'est pourquoi celui-ci doit être à l'affût des indices pouvant évoquer les mauvais traitements: des ecchymoses à divers stades d'évolution, un comportement inusité chez un enfant, une mésentente dans la famille. Les possibilités de prévention et de traitement se situent sur plusieurs plans: le recours aux services sociaux, les poursuites judiciaires, l'utilisation des valeurs positives au sein de la famille, la thérapeutique visant à apprendre à l'individu comment faire face à ses difficultés. Les auteurs font état d'un grand nombre d'agences au Canada qui sont susceptibles d'assister la personne maltraitée.

Both the medical profession and the public are becoming ever more sensitized to the tragedy of family violence. This article addresses the three principal types of family violence: wife battering, child abuse and abuse of the elderly. Our objective is to provide a general overview of the subject, to alert the practitioner to possible symptom–sign complexes and to supply information concerning treatment.

Wife battering

Wife battering constitutes 76% of all episodes of family violence,[1] and 10% of Canadian women who are married or in a live-in relationship are battered every year.[2] In the United States the estimate is even higher: in interviews with 2000 families 16% of the couples reported one or more violent incidents.[2]

Wife battering is a general term for violence that a husband or a male companion does to his wife or the woman with whom he lives. It may also refer to the battering of one member of a lesbian couple. Characteristically, although the "wife" does not consent to the battering, it is condoned by the attitudes, traditions and even laws of the society in which it occurs. MacLeod[3] recently defined it as "violence, physical and/or psychological, expressed by a husband or a male or lesbian live-in lover toward his wife or his/her live-in lover, to which the 'wife' does not consent, and which is directly or indirectly condoned by the traditions, laws and attitudes prevalent in the society in which it occurs".

Wife battering is characterized as a vicious cycle consisting of three phases. The first is a series of minor incidents of abuse, verbal or physical, that increase tension between the spouses. The second phase is a major battering that may leave the wife in a state of emotional shock lasting from a few minutes to a few days. In the third phase the assaulter* conciliates the wife, becomes apologetic and loving, and often swears that the violence will not occur again. He may threaten suicide if the wife plans to leave, and typically she remains in the marital home. Regardless of the circumstances of the original incident, the cycle is likely to be repeated, sometimes with increasing severity.[4]

Many of these women continue to live with their batterer because they feel trapped by financial depen-

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This article was adapted from a report produced by the CMA's Council on Health Care and approved by the General Council of the association. Reprints, in the form of a bilingual monograph, are available to CMA members upon request to Dr. Normand P. Da Sylva, CMA House, PO Box 8650, Ottawa, Ont. K1G 0G8. The charge for nonmembers is $4. Cheques should be made payable to the Canadian Medical Association. Une version française du rapport est en voie de distribution à tous les membres francophones de l'AMC.

*As a legal term "assault" means a threat of attack without physical contact. In this paper, as in common usage, it is used in a more general sense to include battering.

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dence, low self-esteem caused by physical and psychologic abuse, fear of being on their own, emotional attachment, or concern over the future of their children or because they are unaware of their rights and options.

The assaulted woman is often reluctant to tell the truth about how she was injured. She may be ashamed of being beaten or may fear a retaliatory beating from her husband. However, when she does seek help, at least for her injuries, the health professional is often the first and only "outsider" that she contacts. As Wilcoxen[1] pointed out, between 60% and 80% of assaulted women seek professional medical care. Thus, the health care system is a crucial point in the identification of abuse and prevention of further abuse.

If physicians are to recognize patterns of injury symptomatic of battering they must be sensitized to the condition. Studies suggest, however, that abuse has remained virtually unrecognized by the medical profession.[5,6] The Standing Committee on Health, Welfare and Social Affairs of the House of Commons, in its 1982 report on wife battering,[7] noted that some professionals do not elicit information about the beating (or do not think to ask about it), some do not believe the information when it is given, and some tend to blame the victim for provoking the violence. The committee suggested that professional faculties and associations train their students and members to be aware that wife battering is a problem, to be suspicious of certain symptoms, to be prepared to elicit information from a woman who is suspected of being beaten if she does not advance it, to be sympathetic and to refer her to other services that can help her.

Signs and symptoms

Emergency department visits: As Macleod[8] pointed out, wife assault is more likely to happen in the evening, through the night or on weekends (i.e., outside of regular office hours). Consequently hospital emergency department staff are more likely to encounter a woman directly after a severe assault than are the office physician and staff.

Wilcoxen[9] outlined the five primary categories of injuries that an assaulted woman may exhibit at the emergency department and that should arouse the physician's suspicions:

- Bleeding injuries, especially to the head and face.
- Internal injuries, concussions, perforated ear drums, abdominal injuries, especially if the battered woman is pregnant, severe bruising, eye injuries and strangulation marks on the neck.
- Broken or fractured jaws, arms, pelvises, ribs, clavicles and legs.
- Burns from cigarettes, appliances, scalding liquids and acids.
- Psychologic trauma, anxiety attacks of hyperventilation, palpitations, severe crying spells and suicidal tendencies.

Office visits: The abused woman who visits her doctor often presents with such injuries as damaged ear drums or twisted or stiff neck and shoulder muscles or symptoms such as headaches, depression or stress-related conditions (e.g., insomnia, violent nightmares, anxiety, extreme fatigue, eczema, loss of hair).[10] The woman may talk of having "problems" with her husband or may say that her husband is very jealous or impulsive, abuses drugs or is an alcoholic. Abused women sometimes return again and again with new complaints when they are searching for new ways of coping. It should be noted that pregnancy increases a woman's susceptibility to assault.[8] Physicians caring for pregnant women should watch for the signs of abuse.

In addition to noting symptoms in the woman, the physician can observe the children for signs of stress due to family violence. They may have many emotional, behavioural and sleep problems. Boys, in particular, may display aggressive behaviour.[6]

Assessment and management

If battering is suspected the physician should interview the patient alone: she will not feel free to talk if her batterer is nearby. She should be asked directly, but in an unintimidating fashion, whether she has been injured by her husband or boyfriend. If she has been, she should be encouraged to talk about the incident. However, she may deny being battered, remain silent or blame herself because she may feel that it is not safe or appropriate to do anything else. The physician's support and respect for her situation and safety may be the first indication to her that the battering is serious and is not her fault. This attitude will often help her consider alternatives.

The physician should assess the patient's and her children's present danger. There is a positive relation between child and wife abuse.[6] If the woman's injuries are serious she should be hospitalized to ensure her physical security and to instil in both the woman and her batterer the idea that the situation is serious. The woman should be informed that she and, if appropriate, her children are at risk for future battering.

If the patient presents at the physician's office she should not be hurried. When it is impossible for the physician to attend immediately to the woman, she should receive some form of professional attention from the staff until he or she can see her personally. The physician should make every attempt not to dissuade the woman by rescheduling her appointment. Because seeking help often involves further risk, the woman may feel she is unable to return for a second appointment.

When prescribing tranquillizers the physician should remember that there are limitations to the amount and type of change they can effect. Tranquillizers merely treat symptoms; in addition, prescription of tranquillizers implies that the battering is the woman's problem. When such drugs are prescribed, more than a 2-week supply is considered inadvisable.[11]

Referral assistance

The battered woman should be provided with referral assistance. Intervention by the physician should be aimed not at making decisions for the woman but at facilitating her ability to think through alternatives and to choose an acceptable course of action.

There is a tremendous disparity among community services for battered women. However, since almost

all organizing and provision of services have come from community women's organizations rather than from the legal, social service or health care systems, the local women's centre or crisis line has the necessary information.

Resources for battered women include transition houses, emergency shelters, crisis intervention teams, battered women's support groups and legal advocacy groups. While it is recommended that the batterer rather than the victim leave the marital home, this is not always practical. Consequently transition houses exist to provide accommodation and support for battered women and their children for a few days to a few months. Some houses offer counselling and support after the woman has left the house. Crisis intervention teams consist of professionals from various disciplines who provide information and counselling to victims of violence.

Appendix I lists transition houses, emergency shelters, crisis intervention teams and provincial associations for battered women and their children in Canada. Even though these facilities have not been endorsed by the CMA and the list will become outdated with time, it has been included for easy reference.

In communities where no organized services exist the physician may want to become more directly involved by assisting the woman in finding appropriate accommodation, offering to call the police or directing her to another health care professional more experienced in dealing with assaulted women. If the woman feels she must return home or has been noncommunicative, the physician may set up an appointment to check on her condition in a week's time.

In addition, displaying brochures and business cards of local services, such as sympathetic lawyers, in the office, clinic or ward is useful. While the battered woman may not be prepared to use the services immediately, she will be able to "pocket" the information for future reference.

Medical records

Only with well documented recording of the patient's injuries will a recurring pattern of battering become evident and alert the physician to take constructive action.

In addition, well documented medical records can be used to substantiate allegations of assault. Police officers as well as the victim may charge the batterer with assault. A good medicolegal report should indicate the length of time the physician has provided services to the woman (and her children, if appropriate). It should also include what the woman reported about the assaults by her husband and other unsatisfactory elements in the marital relationship. The physical injuries she presented, including injuries that might be considered minor, the extent to which the injuries are consistent with the assault, and the medication or treatment prescribed should also be noted.[12]

Child abuse

According to the Child Welfare Act of Ontario,[13] child abuse occurs if a person who has the care or custody of a child causes or allows the child to suffer the following: physical harm, such as external or internal bruises, burns, fractures, wounds, brain damage or poisoning; malnutrition (including dehydration) or mental ill-health of a degree that if not immediately remedied could seriously impair growth and development or result in permanent injury or death; or sexual molestation. The last will be dealt with in depth in the next section.

Despite clear-cut legal requirements regarding mandatory reporting of suspected cases of child abuse in all the provinces and the Yukon Territory, there is general agreement that under-reporting continues. Additionally, the lack of a universal definition of child abuse and the under-recognition of existing cases make estimating the actual incidence of child abuse very difficult. Robinson[14] maintains that over 8000 cases of physical abuse occur each year in Canada. This coincides with a general estimate of the extent of child abuse of 250 to 350 cases per million population.[15] As well, Robinson suggested that there are probably more than 80 000 cases of child neglect. Dr. Robert Bates, chairman of the board of the Ontario Centre for the Prevention of Child Abuse, suggests that if physical abuse, neglect and sexual abuse are included in the definition the rate is as high as 900 to 1000 cases per million population (personal communication, 1984).

It is commonly acknowledged that abuse occurs within all religious groups and races and in all socioeconomic classes. However, there are differences in the ease with which abuse is identified and disclosed from one socioeconomic group to another. It has been argued that abuse in lower socioeconomic groups is more apparent because of the higher rates of use of public services.

According to Schmitt,[16] the abuser is a related caretaker in 90% of cases, a boyfriend of the caretaker in 5%, an unrelated babysitter in 4% and a sibling in 1%. Overall, adult females and males are equally involved. However, the most important factor is access to the child.

Families at risk

A reduction in the frequency of child abuse will come about from good preventive practices. Patients who may not be successful as parents, even though they may have a normal infant, must be identified during the pregnancy. They can then be offered additional services and help so that they may learn and put into practice good parenting techniques. The characteristics of families at risk are shown in Table I.

Some practical steps in the provision of additional services to such families include seeing the father as early as possible in the pregnancy and discussing with the couple their feelings towards the baby, expectations, role models, areas of strength and problem areas. Additionally, the physician can encourage the parents to attend prenatal and parenthood classes together. The father should be encouraged to attend the labour as well. Rooming-in for the baby while the mother is in the hospital is thought to be advantageous. At this time the parents should be given maximal support, encouragement and teaching by the nurses. The doctor should try to arrange frequent home visits by a public health nurse and possibly a social worker after the baby is born.

Signs and symptoms

In 1962 child abuse received widespread medical attention when Kempe and colleagues[17] reported on a condition called the "battered-child syndrome". The term was used to characterize a clinical condition in young children who had received serious physical abuse, generally from a parent or foster parent. Symptoms of the condition, they suggested, included fracture of any bone, subdural hematoma, failure to thrive, soft-tissue swelling or skin bruising, sudden death, or inconsistency between the type and degree of injury and the explanation given for it.

Since that time, indicators of physical abuse[18] have been expanded to include bruises, welts, lacerations or abrasions of varying age. Typically they are located on the face, torso, back, buttocks, back of the legs or external genitalia and are clustered, forming regular patterns or taking the shape of the article used to inflict the injury. Burns may also be indicators of abuse. They include small, circular burns, immersion burns, rope burns and patterned burns indicating a hot object such as a stove element. Fractures of the skull or facial bones and dislocation of the shoulder or hip are also signs. Other indicators include bald patches on the scalp, subdural hematoma in children under 2 years of age and retinal hemorrhage. Behavioural indicators include wariness of adults, monosyllabic speech, ability to withstand examination and painful procedures with little movement or crying, constant efforts to please the parents, indiscriminate seeking of affection, and behavioural extremes such as aggressiveness or withdrawal.

Indicators of physical neglect[19] have been expanded to include underweight, poor growth patterns, failure to thrive, fatigue, listlessness, poor physical hygiene, unattended medical and dental needs, a consistent lack of supervision and abandonment. Behaviourally, infants may be dull and inactive, and the older child may beg or steal food, be frequently absent from school, wear clothing that is inappropriate for the weather, assume adult responsibilities, engage in delinquent acts, or abuse alcohol or street drugs. Additionally, a mental or emotional developmental lag may be apparent. The child may exhibit hyperactive/disruptive behaviour or sleep disorders, threaten or attempt suicide, or present with psychosomatic complaints such as headache, nausea or abdominal pain.

Along with being alert to the indicators of child abuse, physicians should note the alleged method of injury. Common explanations include the following: the child fell from a chair, a lap or down the stairs; the child was running away scared; a sibling caused the injury; or the hot water was turned on by mistake.[20] These are inconsistent explanations that should at least warn the physician that further investigation is necessary.

Reporting requirements

A physician faced with a suspected case of child abuse must act on his or her suspicions. Mandatory reporting legislation exists in all the provinces and the Yukon Territory. While all adults who believe or suspect that a child is in need of protection have a duty to report this to the authorities, in some provinces professionals who are in contact with children have a specific obligation to report such cases. The Child Welfare Act of Ontario,[21] for example, states:

> Every person who has reasonable grounds to suspect in the course of the person's professional or official duties that a child has suffered or is suffering from abuse that may have been caused or permitted by a person who has or has had charge of the child shall forthwith report the suspected abuse to a Children's Aid Society. . . .Every person who contravenes Subsection 2 of Section 49 is guilty of an offence and on summary conviction by the court is liable to a fine of not more than $1,000.

Appropriate provincial legislation should be referred to for provincial variations.

The physician must be able to give sufficient information to establish who has been abused, what type of abuse it appears to be and what degree of urgency of action is required. In the long term, the Child Welfare Act in Ontario allows the Children's Aid Society to go to court to obtain further information from a physician's medical record if this is deemed necessary to the investigations.

Assessment and management

Under ideal circumstances each community should have a child abuse team consisting of a physician, a child welfare worker and a police officer along with possible involvement of legal advisers, mental health and pediatric resources, the education system and voluntary self-help groups. The team should meet regularly to discuss cases and to work out members' roles and interfaces. However, the child-abuse team, if it does exist, is often not well coordinated and has not effectively evolved a smooth system of operation.[22]

In the case of suspected child abuse a quick screening interview with the child or parent or both should be undertaken to determine what type of abuse has occurred and what degree of urgency of action is required. Parental involvement in the interview process will depend on the degree to which the victim can respond to questions and whether

Table I—Characteristics of families at risk for child abuse[14]

Mother
Under the age of 20
Unmarried
Raised in foster home
Parents separated before she was 15 years old
Neglected or abused
Sibling neglected or abused
Does not want baby
Unwilling or unable to bring child's father to interview
Grossly over- or underweight now or in past
Father
Does not want baby
Absent most of time
Family
Other children require special help or treatment
History of poor dietary habits and indifference to importance of nutrition
Living in poverty
Alcohol or drug abuse
Parents receiving psychiatric or social service care

the caretaker is suspected of being the abuser. The physician should always remember that 90% of all cases of abuse involve a related caretaker. If abuse is suspected the child welfare authorities must be contacted immediately. It is recommended that the parents be kept informed of any action taken.

If the abuse occurred recently or the child is in distress an extended interview should not be delayed. However, ideally a child welfare worker should be present. Once the worker is available a joint interview with the child should be conducted. Because this interview often occurs in a medical setting, the physician's role as interviewer will likely be accepted.

The interview should be held in a private place. It is recommended that a tape recorder be used during the interview so that the child does not have to repeat the experience. A kind, supportive and clear approach, rather than a punitive one, should be used. Open-ended questions, which allow the victim and the parents, if they are involved, to state clearly their perception of what has happened, should be used. The parents should be given an opportunity to clarify inconsistencies or vague explanations. Nonverbal behaviour by the child or parent that is inconsistent with verbal comments should be noted.

A complete medical history of the child should be obtained from the parents. Emphasis is placed on the quality of the parent–child relationship. Indeed, it is necessary to know the emotional reaction of the parents to the pregnancy and to the baby. The family history should also be taken. In addition to the standard description of family structure and health, a very detailed psychosocial history is required. The family history should also include a description of the techniques used to raise and discipline the children, identification of additional sources of emotional support outside the nuclear family, and some description of the parents' own childhood experiences and upbringing.

In cases of serious injury the physician decides whether the child requires admission to hospital. A child in need of protection may also be admitted to hospital to remove him or her from the family, thus allowing for a "cooling-off" period. Hospitalization allows thorough medical investigation, complete assessment of the child's emotional development and observation of the parent–child interaction. Indeed, admission to hospital is not as threatening to parents as is foster care. It is often easier, subsequently, for the child protection worker to establish a rapport with the parents, to identify the major problems and to begin to plan for ongoing family treatment.

It is often valuable to re-examine the child 24 to 48 hours after the initial assessment. At this time it may be possible to find marks that were not visible previously or to record the progress and definition of marks initially seen.

Medical records

Because of the possibility of legal action in cases of abuse, it is essential that the medical record contain an accurate and detailed description of the medical history of the child, the psychosocial history of the family and observations of family interaction during the interviews.[23] Statements made by the child and others should always be quoted verbatim. The sources of any historical information obtained should be indicated. The use of visual aids, such as simple diagrams or entries recorded on specially provided charts that depict body areas, is suggested. Photographs should be obtained when possible. If the photographer or other person present when they were taken is not available to report in court, a witness has to sign the back of the photographs. Materials collected for forensic examination must be labelled as to content, name, date and time and be initialled by the collector and the investigating officer.

Referral assistance

The authorities determine whether abuse has occurred. Whether or not the child remains with the family, the child welfare worker begins a treatment plan composed of a variety of interventions that may differ from region to region. Some agencies have parent aides who are available to work with families on child- and home-management skills. Other agencies offer mothers' groups, which provide social and educational outlets. Family service agencies are private voluntary agencies that provide such services as nursery school programs and mothers' groups. Parents Anonymous is also a service available to abusing parents. In addition, other official health agencies provide prenatal classes and classes in parenting skills.

Table II—Forms of sexual abuse of children

Touching, fondling and physically exploring child's genitalia
Masturbation by male abuser against child's perineum, buttocks, abdomen or thighs
Manual masturbation of abuser by child
All combinations of oral–genital contact between children of either sex and adults of either sex
Actual or attempted anal intercourse with child of either sex
Actual or attempted vaginal intercourse (without force)
Forceful attempt at vaginal intercourse, with local or general trauma
Exhibitionism
Voyeurism
Exploitation of children in preparation of sexually suggestive or pornographic visual materials

Sexual abuse of the child

Sexual abuse of children, the exploitation of the defenceless child by an older person, is usually nonviolent and usually reflects a family problem.[24] Specific forms of sexual abuse are listed in Table II.

As Finkel[24] points out, sexual abuse of children is not confined to any particular stratum of the community. Moreover, often the whole family is in need of help. A high percentage of sexually molested children have a parent who was a sexual abuse victim. The incidence of sexual abuse is unknown, but may

be as high as 1 in 4 for girls and 1 in 10 for boys if all forms of inappropriate sexual behaviour towards children are included.[24] Kinsey and colleagues reported a history of childhood sexual experience in 28% of 1200 adult women interviewed.[24]

Most identified sexual abuse victims are girls. However, as Finkel[24] points out, general acceptance of the victim's being a girl may have prevented adequate attention to the exploitation of boys and disclosure of the actual frequency with which it occurs. Most cases of sexual abuse occur in children at ages 2 to 6 years, when they are most trusting and therefore most vulnerable to exploitation. Another distinct peak occurs between 12 and 16 years, corresponding to pubertal development.

Most commonly, the abuser seems normal in general appearance and behaviour and in most cases is known to the victim. It is uncommon for the abuser to be psychotic, sexually perverted or deranged.

Signs and symptoms

Signs that are suggestive of sexual abuse are shown in Table III.

Reporting requirements

A physician who suspects sexual abuse of a child is under the same obligations as in a case of physical abuse.

Assessment and management

A quick screening interview with the parent or child or both should be undertaken to determine when the event occurred, the nature of the abuse and whether there is trauma. Following this interview, if sexual abuse is suspected the authorities must be contacted. If the preliminary interview reveals no obvious distress or urgency and the event occurred more than 48 hours earlier, arrangements for further interviews are more flexible. Otherwise, the extended interview should not be delayed. The parents or some other supportive person should be present. However, it must be remembered that most abusers are the parents/caretakers themselves. Consequently, if intrafamily abuse or incest is suspected, the parent should be excluded from at least some portion of the interview.

When conducting the interview the physician should maintain an open mind and a calm attitude. The interview should be as reassuring and comfortable for the child as possible and should be a discussion rather than an interrogation. Every effort should be made to establish a relationship with the child before focusing on the details of the experience. The child should be reassured that he or she is not guilty of any crime and will not be punished or hurt. Terminology that the child understands should be used.

In addition to a complete medical history of the child, the family history should be taken. Along with the standard description of family structure and health, a very detailed psychosocial history is required.

The physical examination* has five components: general physical examination, specific examination of the genital and anal areas, screening for problems related to sexual activity, collection of samples necessary for forensic evaluation, and reassurance. The medical component of the assessment of a potentially sexually abused child requires skill and experience. Physicians who are inexperienced or uncomfortable with such an assessment should refer the case to a more experienced and skilled colleague whenever possible. However, it should not be assumed that because the problem is labelled "sexual" a gynecologist is the correct consultant. Most gynecologists are not trained or experienced in dealing with children.

For the same reason as in instances of physical abuse, it is often valuable to re-examine the child 24 to 48 hours after the initial assessment. In addition, the second visit provides an opportunity for older children to ask questions and clarify information.

The initial therapeutic intervention is reassurance and the provision of continuing emotional support for the child until more sophisticated therapeutic measures are established. These may include counselling for individual family members leading to joint sessions (mother/child, father/child, father/mother), individual play or counselling sessions with the child, or group sessions with other victims.[25]

Medical records

The medical records should contain an accurate and detailed description of the medical history of the child, the psychosocial history of the family, statements made by family members and the results of the physical examination.

Referral assistance

At the time of the first contact an assessment and immediate decision must be made by the child welfare authorities regarding the child's safety in his or her own home. If there is any doubt about the safety of the home, the child should be placed in a foster home or hospital during further investigation and deliberation.

*For a detailed description of the physical examination and treatments see reference 22.

Table III—Signs suggestive of sexual abuse of children[24]

Sexually transmitted disease in prepubertal child (often also symptomatic in sexually active postpubertal child)
Vulvovaginitis
Soreness, bleeding or discharge in vaginal area, especially if child seems seductive or precocious in behaviour
Evidence of physical manipulation of or foreign body in vagina
Representation of genitalia in preschooler's drawings that suggests specific exposure to adult genitalia
Seductive behaviour
Sexual knowledge inappropriate for child's age
Severe psychosomatic symptoms in prepubertal, pubertal or adolescent child
Severe acting-out (running away from home, arson, stealing)
Sexually precocious behaviour in young teenager
Pregnancy in young teenager, especially when father is unnamed
Self-destructive behaviour (drug abuse, attempted suicide)

Ultimately the authorities determine whether sexual abuse has occurred. Whether or not the child remains with the family, a treatment plan is initiated.

Abuse of the elderly

Like the very young, the very old are among the most physically and emotionally vulnerable members of society. And, like the very young, the very old are abused. Abuse of the elderly is any act of commission or omission that results in harm to an elderly person.[26] Types of abuse of the elderly are shown in Table IV.

It is estimated that in the United States 1 million elderly persons are battered, neglected or exploited each year by family members or caretakers.[27] By extrapolation, 100 000 elderly Canadians may be abused annually. The results of 105 interviews of health and social service professionals in Manitoba revealed 402 cases of abuse.[28] Lau and Kosberg,[29] in an exploratory study of abusive behaviour in 484 cases of clients of the Chronic Illness Center in Cleveland, found a rate of abuse of 9.6%. The abuse included beatings, extreme neglect, verbal abuse, threats, theft, misuse of funds, forcing the elderly family member out of the home and questionable institutionalization.

As for child abuse, establishing a confident estimate of the incidence of abuse of the elderly is complicated by three factors: lack of a standard definition, under-reporting and lack of recognition. Indeed, abuse of the elderly is difficult to detect because of the relative isolation of the victims. Only approximately 5% of the elderly reside in institutions.[30]

Table IV—Types of abuse of the elderly

Physical
Assault
Rough handling
Gross neglect
Withholding food or personal or medical care
Psychosocial
Confinement
Isolation
Lack of attention
Intimidation
Verbal or emotional abuse
Financial
Withholding finances
Fraud
Theft
Misuse of funds
Withholding means for daily living

The literature suggests that the greatest source of abuse of the elderly is the family. Hickey and Douglass, in a study involving a variety of practitioners providing services to the elderly, reported that in 93% of the cases of abuse studied a family member was the abuser.[31] Lau and Kosberg's research suggested that abuse was inflicted by family members.[29] The Manitoba Council on Aging's report on elder abuse[28] revealed that, in a sample of 400 cases, the son was the most likely abuser, followed by the daughter, then the spouse. A large number of the abusive caregivers were over 60 years of age themselves. The type of abuse most frequently encountered was financial, followed by psychosocial and physical. The most common form of financial abuse involved caregivers cashing the elderly person's pension/social insurance cheques and withholding the funds. Verbal or emotional abuse was the most frequent type of psychosocial abuse, and assault the most frequent type of physical abuse.[32]

There is a close parallel between abuse of children and of the elderly by family members. Like the young child, the aged parent is dependent on the caregiver and can be an emotional, physical and financial burden to the family. Given the lack of facilities and services available to care for the aged family member, some families, overwhelmed by the constant supervision required and the lack of support, intentionally or unintentionally abuse the elderly person.

The vulnerable and frail elderly are often unable to provide their own protection and are, moreover, frequently reluctant or unwilling to bring charges against their abuser, particularly since the abuser is often a family member, close friend or neighbour. Indeed, a double bind traps many elderly persons when they recognize their dependency on the abuser. Thus, they may elect to remain silent because of a lack of alternative shelter, fear of abandonment, of reprisal, of institutionalization or of the unknown, or a desire to avoid the shame, embarrassment and stigma that often ensue.[31]

In one study the victims of abuse were women aged 65 years or older that had physical or mental disabilities or both.[27] The Manitoba study[28] suggested that victims of abuse are likely to be women aged 80 to 84 years who have resided with a family member for 10 or more years. However, the demographic weight of women in the elderly population must be considered: the proportion of elderly women involved in cases of abuse may be somewhat congruent with their proportion in the ageing population.

Signs and symptoms

According to Minaker, physicians can often spot indications of abuse or neglect.[27] The signs may include injuries that are inconsistent with the explained cause, including bruises in various stages of healing; inconsistent medical history and laboratory findings, which suggests poor health care surveillance; medications that are inappropriate to the patient's condition (e.g., "restraint by medication"); and poor overall physical and skin condition, which suggests poor caregiver surveillance.

The Seven Oaks General Hospital protocol includes other circumstances that are suggestive of abuse.[33] One such sign is undernourishment and dehydration in an elderly person whose mental alertness enables the expression of needs but whose immobility prevents him or her from meeting these needs independently. Additionally, denial of any problem, overprotectiveness towards the care providers, resignation, withdrawal or passivity, and fear are all emotional reactions that may signal abuse.

Assessment and management

Accurate and complete information for the medical record should be obtained. This is especially important if legal decisions are made concerning the abused person. Additionally, it is important to establish a positive relationship with the elderly person and the caregiver–abuser. Stresses on family members re-

sulting from overwhelming responsibilities can be lessened and long-term conflicts recognized and dealt with when those involved feel acceptance rather than frustration and despair. In some cases, however, intervention is impossible because the caregiver refuses to allow outsiders access to the site of the abuse. Other clients, because of counterbalancing factors or because the alternatives appear worse or more frightening, remain in situations in which they are abused.

Intervention such as counselling, engagement of additional relatives or home aides, and regular medical or nursing care can enable some persons to remain where they are with less risk. Moving from the home is ordinarily the last choice of intervention. It can be accomplished with consent following counselling or, if necessary, through the legal process, including appointment of a legal guardian.

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Appendix I—Transition houses, emergency shelters,* provincial associations, and crisis intervention teams for battered women in Canada[34] (These facilities have not been endorsed by the CMA.)

Transition houses and emergency shelters

Northwest Territories

YWCA–Emergency Shelter
Yellowknife, NWT
(403) 873-4767
920-2777

Yukon Territory

Kaushee's Place
Whitehorse, Yukon
(403) 668-5733

British Columbia

Burnaby Emergency Shelter for Women and Children
Burnaby, BC
(604) 291-1218

Marguerite Dixon House
Burnaby, BC
(604) 525-3223

Ann Davis Transition House
Chilliwack, BC
(604) 792-3116

Cranbrook Safe Homes
Cranbrook, BC
(604) 426-8407

Mizpah House
Dawson Creek, BC
(604) 782-9176

*Emergency shelters provide accommodation to women in crisis; however, they do not necessarily offer the same services as transition houses. Some may exclude children, and some may also provide accommodation to men.

Elk Valley Safe Homes
via Fernie District Hospital
Fernie, BC
(604) 423-4453

Fort Nelson Women's Emergency Shelter
Fort Nelson, BC
(604) 774-3729

Meope Transition House
Fort St. John, BC
(604) 785-5208

The "Y" Women's Emergency Shelter
Kamloops, BC
(604) 374-6162

Kelowna Women's Emergency Shelter
Kelowna, BC
(604) 763-1040

Ishtar Transition House
Langley, BC
(604) 530-9442
588-0188 (after hours)

Mission Transition House
Mission, BC
(604) 826-3269

Haven Transition House
Nanaimo, BC
(604) 754-7123

Nelson Emergency Shelter Programme
Nelson, BC
(604) 352-3504

Emily Murphy House
North Vancouver, BC
(604) 987-3374

Haven House
Parksville, BC
(604) 248-2093

Port Alberni Transition House
Port Alberni, BC
(604) 724-2223

Port Coquitlam Women's Transition House
Port Coquitlam, BC
(604) 464-2024

Phoenix Transition House
Prince George, BC
(604) 563-7305

Maud Bevan Transition House
Prince Rupert, BC
(604) 627-8588

Amata Transition House
Quesnel, BC
(604) 992-7321

Nova House
Richmond, BC
(604) 270-4911
via Chimo Richmond Crisis Centre
(604) 273-8701

Shuswap Area Family Emergency Shelter (SAFE Society)
Salmon Arm, BC
(604) 832-9616

Sunshine Coast Transition House
Sechelt, BC
(604) 885-2944

Surrey Emergency Shelter
via Emergency Services
Surrey, BC
(604) 576-8636

K'san House
Terrace, BC
(604) 635-6447
638-9982

Women in Need Society Transition House
Trail, BC
(604) 364-1718

Munroe House
Vancouver, BC
(604) 734-5732

Powell Place Sanctuary for Women
via Emergency Services
Vancouver, BC
(604) 668-3111

Vancouver Rape Relief and Women's Shelter
Vancouver, BC
(604) 872-8212

Vancouver Transition House
Vancouver, BC
(604) 734-3358

Vernon Women's Transition House
Vernon, BC
(604) 542-1122

Victoria Women's Transition House
Victoria, BC
(604) 385-6611

Alberta

Calgary Women's Emergency Shelter
Calgary, Alta.
(403) 245-5901

Discovery House
Calgary, Alta.
(403) 290-0500

Sherif King Home
Calgary, Alta.
(403) 266-0707

Dr. Margaret Savage Women's Crisis Centre
Cold Lake, Alta.
(403) 594-3353

WIN Houses I and II
Edmonton, Alta.
(403) 479-0058

Unity House
Fort McMurray, Alta.
(403) 791-7505

Odyssey House
Grande Prairie, Alta.
(403) 532-2672

Harbour House
Lethbridge, Alta.
(403) 320-1881

Lloydminster Interval Home
Lloydminster, Alta.
(403) 875-0966
(also serves Saskatchewan)

Medicine Hat Women's Shelter
Medicine Hat, Alta.
(403) 529-1091

Central Alberta Women's Emergency Shelter
Red Deer, Alta.
(403) 346-5643

Saskatchewan

Moose Jaw Transition House
Moose Jaw, Sask.
(306) 693-6511

Battleford's Interval House
North Battleford, Sask.
(306) 445-2742

Pesim Waskayikan Interval House
Prince Albert, Sask.
(306) 922-2100

Regina Native Women's Residence Resource Centre
Regina, Sask.
(306) 545-2062

Regina Transition House
Regina, Sask.
(306) 569-2292

Interval House Inc.
Saskatoon, Sask.
(306) 244-0185

Manitoba

Westman Women's Shelter–YWCA
Brandon, Man.
(204) 727-3644

Dauphin Crisis Centre
Dauphin, Man.
(204) 638-8777

Women's Shelter
Portage La Prairie, Man.
(204) 239-5232

Aurora House Crisis Shelter
The Pas, Man.
(204) 623-5497

North WIN House
Thompson, Man.
(204) 778-7273

Native Women's Transition Centre
Winnipeg, Man.
(204) 589-1859

Osborne House Crisis-Shelter for Battered Women
Winnipeg, Man.
(204) 775-8197

Ontario

Atikokan Crisis Home
Atikokan, Ont.
(807) 597-4239
via police (807) 597-2777

Yellow Brick House
Aurora, Ont.
(416) 727-8591
883-3609

Women and Children Crisis Centre
Barrie, Ont.
(705) 728-6300

Huron County Family Crisis Centre
Bayfield, Ont.
(519) 482-7988

Nova Vita Women's Shelter
Brantford, Ont.
(519) 753-1000

YWCA–Crisis Housing
Brantford, Ont.
(519) 752-6568

Family Crisis Shelter
Cambridge, Ont.
(519) 653-2422

Lanark County Interval House
Carleton Place, Ont.
(613) 257-5960

Chatham–Kent Women's Centre
Chatham, Ont.
(519) 354-6360

Maison Bladwin House
Cornwall, Ont.
(613) 938-2958

Avoca House
Eganville, Ont.
(613) 628-2522

Elliot Lake Women's Crisis Centre
Elliot Lake, Ont.
via police (705) 848-7101
via hospital (705) 848-7181

Women's Habitat
Etobicoke, Ont.
(416) 252-5829

Janus Forbes Transition House
Native Women's Shelter
via Thunderbird Friendship Centre
Geraldton, Ont.
(807) 854-0630

Guelph/Wellington Women in Crisis
Guelph, Ont.
(519) 836-5710

Hamilton Native Women's Centre
Hamilton, Ont.
(416) 522-1501

Hope Haven
Hamilton, Ont.
(416) 547-1815

Inasmuch House
Hamilton, Ont.
(416) 529-8149
529-8140

Maison Interlude House
Hawkesbury, Ont.
(613) 632-1131

Habitat Interlude
Kapuskasing, Ont.
(705) 337-1122

Kingston Interval House
Kingston, Ont.
(705) 546-1777

Anselma House
Kitchener, Ont.
(519) 576-0540
742-5894

Family Centre–Mission Services of London
London, Ont.
(519) 433-0641

Women's Community House
London, Ont.
(519) 439-4543

Halton Women's Place
Milton, Ont.
(416) 878-8555

Interim Place
Mississauga, Ont.
(416) 271-1860

Niagara Women in Crisis
Niagara Falls, Ont.
(416) 356-5800

Nipissing Transition House
North Bay, Ont.
(705) 476-2429

North Bay Crisis Centre
North Bay, Ont.
(705) 474-1031

Higgins House–YWCA
Oshawa, Ont.
(416) 576-8880

Maison d'Amitié/Amity House
Ottawa, Ont.
(613) 234-7204

Ottawa–Carleton Interval House
Ottawa, Ont.
(613) 234-5181

Women's Centre (Grey–Bruce Inc.)
Owen Sound, Ont.
(519) 371-1600

Bernadette McCann House for Women
Pembroke, Ont.
(613) 732-3131

Crossroads–YWCA
Peterborough, Ont.
(705) 743-4135

Ernestine's Women's Shelter
Rexdale, Ont.
(416) 746-3701

Women's Place
St. Catharines, Ont.
(416) 684-8331

Women's Place
St. Thomas, Ont.
(519) 631-9800

Women's Interval Home of Sarnia–Lambton
Sarnia, Ont.
(519) 336-5200

Women in Crisis Home
Sault Ste. Marie, Ont.
(705) 256-8249
256-7101

Emily Stowe Shelter for Women
Scarborough, Ont.
(416) 264-4357

Optimism Place
Stratford, Ont.
(519) 271-5550

Genevra House
Sudbury, Ont.
(705) 674-2210

Beendigen Native Women's Crisis House
Thunder Bay, Ont.
(807) 622-5101

Community Residence
via Social Services Department
Thunder Bay, Ont.
(807) 623-2711, ext. 2430

Faye Peterson Transition House
Thunder Bay, Ont.
(807) 345-7456

Anduhyaun House (Native Women's Shelter)
Toronto, Ont.
(416) 920-1492

Interval House Inc.
Toronto, Ont.
(416) 924-1491

Nellie's
Toronto, Ont.
(416) 461-1084

Street Haven
Toronto, Ont.
(416) 967-6060

Women in Transition
Toronto, Ont.
(416) 967-5227

Women's Place: Welland Centre
Welland, Ont.
(416) 788-0113

Hiatus House
Windsor, Ont.
(519) 253-4458

Women's Emergency Centre
Woodstock, Ont.
(519) 539-1439

Quebec

La Passerelle
Alma, PQ
(418) 668-4671

La Passerelle
Amos, PQ
(819) 732-9161

Envol d'Asbestos
Asbestos, PQ
(819) 879-7533

Maison des femmes de la Côte-Nord
Baie-Comeau, PQ
(418) 296-4799
296-4733

Maison Fafard
Baie-St-Paul, PQ
(418) 435-2550
435-3520

Centre féminin du Saguenay
Chicoutimi, PQ
(418) 549-4343

Horizon pour elles
Cowansville, PQ
(514) 263-5046

La Rose des vents du Drummond
Drummondville, PQ
(819) 472-5444

Centre Mechtilde
Hull, PQ
(819) 777-2952

Maison d'accueil la Traverse
Joliette, PQ
(514) 759-5882

La Parados
Lachine, PQ
(514) 637-3529

La Bouée régionale
Lac-Mégantic, PQ
(819) 583-1233

Le Toit de l'amitié
La Tuque, PQ
(819) 523-7829

Maison le Prélude
Laval, PQ
(514) 682-3050

Jonction pour elle
Lévis, PQ
(418) 833-8002

Carrefour pour elle
Longueuil, PQ
(514) 651-5800

La Gigogne
Matane, PQ
(418) 562-3377

Passe-R-Elles des Hautes-Laurentides
Mont-Laurier, PQ
(819) 623-1523

Assistance aux femmes de Montréal
Montreal, PQ
(514) 270-8291

Auberge de transition
Montreal, PQ
(514) 481-0495

Centre Inter-Val
Montreal, PQ
(514) 933-8488
933-8489
933-8480

Centre Refuge Montréal
Montreal, PQ
(514) 523-1095

Le Chaînon
Montreal, PQ
(514) 845-0151

La Dauphinelle
Montreal, PQ
(514) 253-1224

L'Escale pour elle
Montreal, PQ
(514) 351-3374

Maison d'hébergement d'Anjou
Montreal, PQ
(514) 351-6134

Maison du réconfort
Montreal, PQ
(514) 932-9171

Maison Marguerite
Montreal, PQ
(514) 932-2250

L'Ombre-Elle
Ste-Agathe-des-Monts, PQ
(819) 326-1321

Maison Hélène Lacroix
Ste-Foy, PQ
(418) 527-4682

Coup d'elle
St-Jean-sur-Richelieu, PQ
(514) 346-1645

Le Mitan Inc.
Ste-Thérèse-de-Blainville, PQ
(514) 435-3651

Le Centre d'hébergement
Shawinigan, PQ
(819) 537-8348

L'Escale de l'Estrie
Sherbrooke, PQ
(819) 569-3611

La Source
Sorel, PQ
(514) 743-2821

La Gitée
Thetford Mines, PQ
(418) 335-5551

Résidence de l'avenue A
Trois-Rivières, PQ
(819) 376-8311

Maison d'hébergement le Nid
Val-d'Or, PQ
(819) 825-3865

Accueil du sans-abri
Valleyfield, PQ
(514) 371-4618

Centre d'hébergement l'Entre-temps
Victoriaville, PQ
(819) 758-6066

Centre amical de la Baie
Ville-de-la-Baie, PQ
(418) 544-4626
544-7490

New Brunswick

Foyer d'accueil Vallée Lourdes
Bathurst, NB
(506) 548-2350

Maison Notre-Dame
Campbellton, NB
(506) 753-4703

Centre de dépannage
Edmundston, NB
(506) 735-6859
735-3971

Fredericton Transition House
Fredericton, NB
(506) 455-1498

Cross Roads for Women
Moncton, NB
(506) 382-2002

Hestia House
Saint John, NB
(506) 642-2493

Fundy Region Transition House
St. Stephen, NB
(506) 466-4485

Accueil Ste-Famille
Tracadie, NB
(506) 395-2212

Prince Edward Island

Anderson House
Charlottetown, PEI
(902) 892-0960

Nova Scotia

Byrony House
Halifax, NS
(902) 422-7650

Cape Breton Transition House
Sydney, NS
(902) 539-2945

Newfoundland and Labrador

Transition House
Cornerbrook, Nfld.
(709) 634-4198

Transition House
St. John's, Nfld.
(709) 753-1461

Labrador West Safe House Project
Labrador City, Lab.
(709) 944-3600

Provincial associations

British Columbia and Yukon Territory
BC/Yukon Society of Transition Houses
c/o Munroe House
PO Box 33904, Stn. D
Vancouver, BC
V6J 4L7
(604) 734-5722

Alberta
Alberta Council of Women's Shelters
c/o Edmonton Women's Shelter Ltd.
Rm. 4, 11602–40th St.
Edmonton, Alta.
T5W 2K6
(403) 471-6709

Manitoba
Manitoba Committee on Wife Abuse
Fourth floor, 777 Portage Ave.
Winnipeg, Man.
R3G 3L1
(204) 774-1794

Ontario
Ontario Association of Interval and Transition Houses
29 Dalton Rd.
Toronto, Ont.
M5R 2Y8
(416) 925-1052

Quebec
Regroupement provincial des maisons d'hébergement et de transition pour femmes victimes de violence
Ste. 375, 515 Viger St. E
Montreal, PQ
H2L 2P1
(514) 842-0607

New Brunswick
New Brunswick Association of Transition House Workers
PO Box 1143
Fredericton, NB
E3B 5C2
(506) 454-1498

Crisis intervention teams

British Columbia
CAR 86 Program
c/o Emergency Services
Ministry of Human Resources
575 Drake St.
Vancouver, BC
V6B 4K8
(604) 668-3111

Alberta
Victim-Crisis Unit
Calgary Police Service
316–7th Ave. SE
Calgary, Alta.
T2G 0J2
(403) 268-2093

Victim Services Unit
Edmonton Police Department
9620–103 A Ave.
Edmonton, Alta.
T5H 0H7
(403) 421-2213

Saskatchewan
Prince Albert Mobile Crisis Unit
1100–1st Ave. E
Prince Albert, Sask.
S6V 2A7
(306) 764-1011

Mobile Crisis Service Inc.
1109–11th Ave.
Regina, Sask.
S4P 0G4
(306) 525-5333
527-0127

Saskatoon Crisis Intervention Service
136 Ave. F S
Saskatoon, Sask.
S7M 1S8
(306) 664-6200

Manitoba
Manitoba Committee on Wife Abuse
400–777 Portage Ave.
Winnipeg, Man.
R3G 3L1
(204) 942-3052
774-1794
1-800-362-3344

Ontario
Family Consultant Service
London Police Force
601 Dundas St.
London, Ont.
N6B 1X1
(519) 438-3291

Domestic Response Team
c/o Family Service Association of Metropolitan Toronto
22 Wellesley St. E
Toronto, Ont.
M4Y 1G3
(416) 787-4241

Quebec
Service d'aide aux femmes victimes de violence
1110 des Roitelets
Sûreté du Québec
Chicoutimi, PQ
G7H 6J6
(418) 549-9266, ext. 258
548-6870

New Brunswick
Restigouche Family Crisis Interveners
PO Box 5001, loc. 307
Campbellton, NB
E3N 3H5
(506) 753-6769 ■