Intimate Partner Violence & Strangulation in the Deaf Community

May 31, 2017

Thank You to Our Sponsor:

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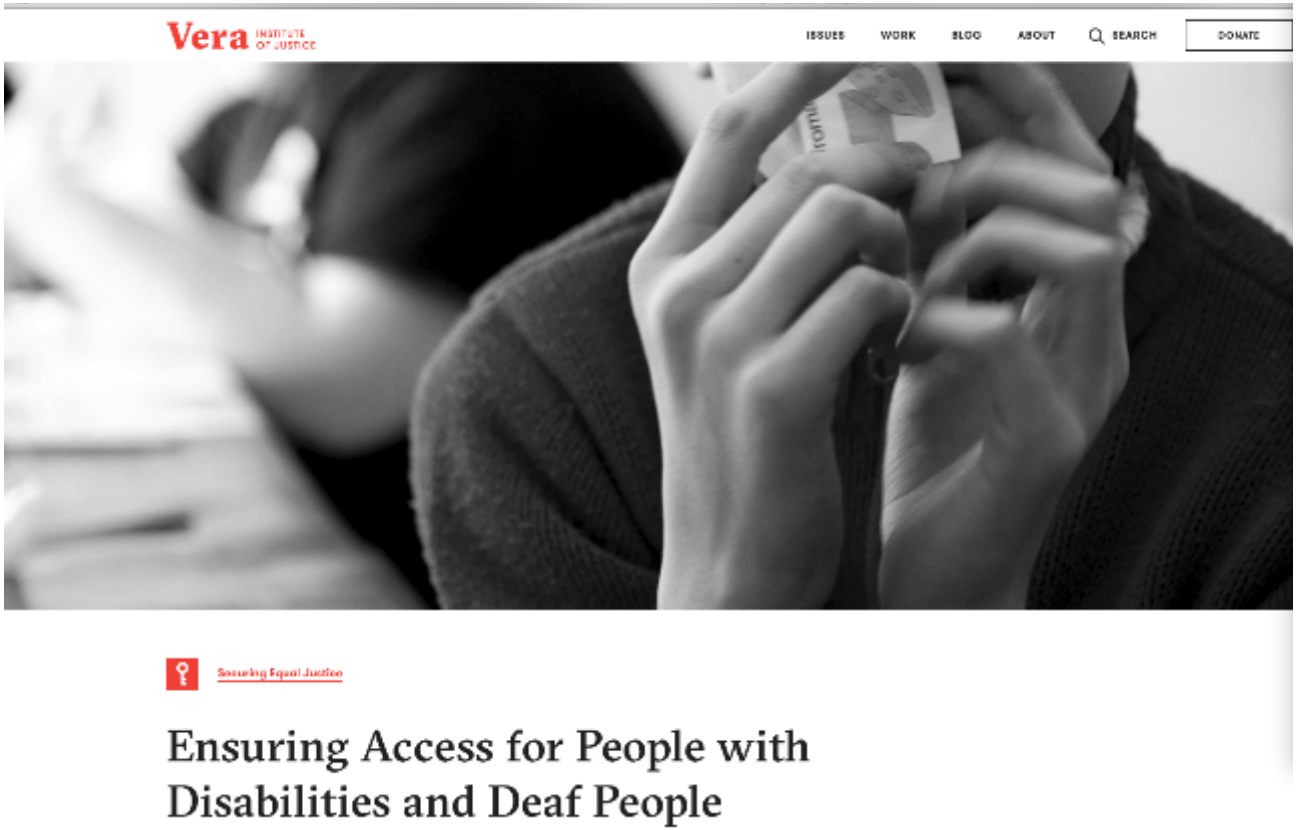


Next Advanced Strangulation Course
October 24-27, 2017
Fort Worth, TX

This Webinar Was Previously Recorded

Please email questions to:
patricia@allianceforhope.com

Your presenter today:

Cindi Cassady, Ph.D.
Consultant/Lecturer with the University of Kibungo, Rwanda

Overview

- Incidence of DV in the Deaf community
- Challenges & barriers in accessing FJCs and helping professionals
- The difficulty with labeling abuse in the Deaf community
- Definition and prevalence of strangulation in DV/IPV
- Signs and symptoms of strangulation
- How to identify a victim of strangulation?
- Why it is important to identify a victim?
- Recommendations on how FJCs can collaborate with the Deaf community about strangulation?
- The importance of international work in GBV, DV and strangulation.

IPV & Disabled Women

- Estimated 83% of women with disabilities will be sexually assaulted in their lifetime. (Stimpson & Best, 1991).
- Experience abuse for longer periods of time and by more perpetrators than non-disabled women. (Nosek, Howland, and Hughes, 2001).
- 49% experienced 10 or more incidents of abuse (Valenti-Heim, 1995).

Societal Attitudes

- Less intelligent
- Less credible
- Non-sexual beings
- They take up too much time
- People feel awkward interviewing a person with a physical or sensory disability.
- Be willing to look at your own ideas and pre-conceived ideas about deaf & disabled people.

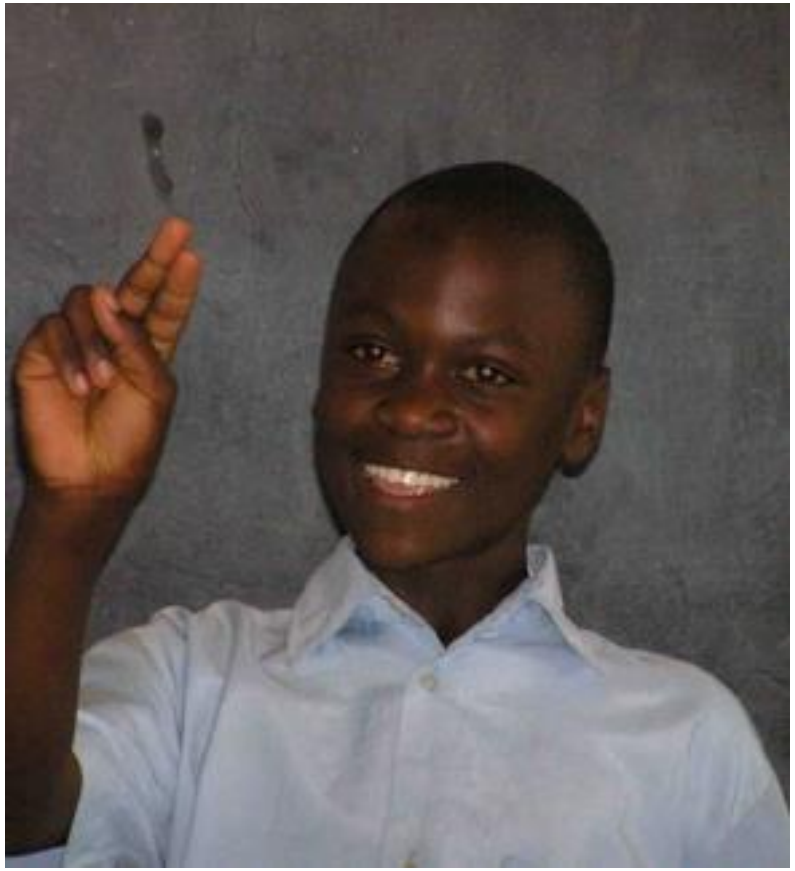
Incidence of DV in the Deaf Community

- 1 in 4 **deaf** women are victims of **domestic violence** (ADWAS stat).
- 1 in 3 **deaf** women are the victims of sexual assault (ADWAS stat).
- Data from an eight-year survey of college students at Rochester Institute of Technology indicates that Deaf and hard of hearing individuals are 1.5 times more likely to be victims of relationship violence including sexual harassment, sexual assault, psychological abuse and physical abuse in their lifetime.

- A 2014 study found that Deaf adults were more likely to experience forced sexual experiences than hearing adults. Deaf survey respondents experienced forced sexual incidents at rates that were at least twice those reported by hearing respondents in other surveys. (Vera Institute of Justice,2014)

A Culture of “Silence”

- Lack of communication at home: 93-95% deaf children born to hearing parents.
- 90% of those parents do not become fluent in ASL.
- Deaf children experience higher incidence of physical/sexual abuse.
- 54% of deaf boys sexually abused.
- 50% of deaf girls sexually abused.
- Less likely to report or to be believed if they report sexual abuse.
- This breeds a culture of “silence”. Why tell?



Challenges

- Their confidentiality is often breached
- Isolated from information about health and safety
- They fear losing their children if they report abuse

Accessibility

- Technology- communicate via texting or video relay. TTYs are technological dinosaurs.
- Often lack of coordinated case management/advocacy services for victims.
- Lack of access to information on support services for Deaf victims/survivors of GBV.
- Lack of accessible shelters
- Lack of accessible transportation

Difficulty Receiving Help

- Deaf woman have increased barriers to services and are likely at greater risk for fatalities. (Grady Nia project , Emory Univ.) http://psychiatry.emory.edu/niaproject/Resources/Deaf.html.

- Within the deaf community, there is a “double code of silence” related to domestic violence because services are typically not culturally sensitive or accessible for deaf survivors and because the deaf community has historically misunderstood or minimized the issue (Rems-Smario, 2007)

UNDERREPORTING

- Women are 5 to 8 times more likely than men to be victimized by an intimate partner.
- Most IPV incidents are not reported to the police - only 20% of rapes/sexual assaults, 25% of physical assaults, and 50% of stalking towards women are reported.
- Despite severe under-reporting of IPV, calls related to IPV make up about half of all violent crime calls to police departments.
- Only about 1 out of 5 IPV victims with physical injuries seek professional medical treatment

Barriers for Deaf & Disabled Women

- Deaf women less likely to report physical or sexual abuse
- Fear of isolation & barriers to communication
- Most do not want to go into shelters and return to abuser
- Believe police will help them but realize many do not use professional, certified interpreters.
- Fear of not being believed if partner is hearing or able to use speech.
- Fear of being ostracized by the Deaf community
- Fear of losing the husband's income if he goes to jail-both receiving disability, SSDI checks.
- Few if any Deaf friendly or accessible resources in their community.

Most at RISK for IPV

- Female
- Ages 18-24
- Age 65 or older
- Deaf or disabled
- Victimized as a child
- Exposed to maternal violence
- Pregnant
- For 30% of women who are abused, the first incident occurs during pregnancy.
- Between 4-8% of pregnant women are abused at least once during pregnancy.
- Women are most at risk for violence during process of separating from their intimate partner.

Lack of Health-Related Knowledge

- Reasons are numerous:
- Parents lack effective strategies for communicating with their Deaf children
- Parent reluctance or embarrassment to provide health education at home,
- Reduction in incidental learning
- Inadequate school instruction
- Many Deaf students relay on their peers to obtain health and sex-related information (Job, 2004).

Labeling DV in the Deaf Community

- Deaf female undergraduates often did not label their experiences of psychological aggression, physical assault, and sexual coercion as abuse, even when these experiences included severe violence. (Anderson & Pezzarossi, 2011).
- Research indicates that the prevalence of psychological, physical and sexual partner violence against Deaf college and community women is nearly double when compared to hearing counterparts (Anderson, 2010, Anderson & Leigh, 2011)
- Women who were more committed to their partners or were still in a relationship with their partners were less likely to label their experiences of physical assault as abuse or battering. (Hamby and Gray-Little, 2000)
- Deaf survivors experience unique issues that serve as barriers to seeking help : issues of language, communication, health literacy and confidentiality. (Schlehofer, Hurwitz, Mowl, & Haynes, 2009)

A little Foundation about Strangulation

- Casey Gwinn, Esq
- President, Alliance for HOPE International

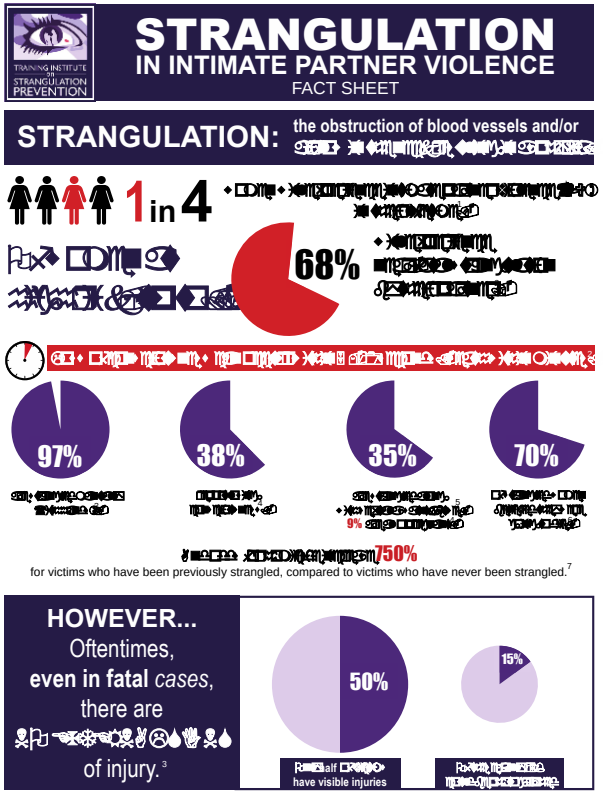
Casey Gwinn, J.D.
President & Co-Founder

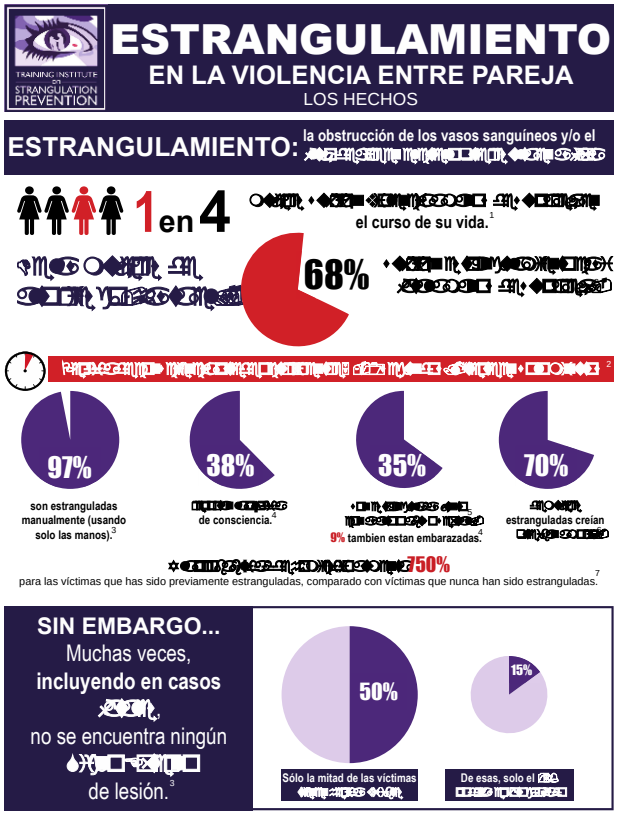
"The most dangerous domestic violence offenders strangle their victims. The most violent rapists strangle their victims. We used to think all abusers were equal. They are not. Our research has now made clear that when a man puts his hands around a woman, he has just raised his hand and said, "I'm a killer." They are more likely to kill police officers, to kill children, and to later kill their partners. So, when you hear "He choked me", now we know you are the edge of a homicide."

Facts About Strangulation

- Strangulation is one of the most lethal forms of domestic violence: unconsciousness may occur within seconds and death within minutes.
- May cause a variety of serious medical conditions with symptoms lasting for weeks after the event
- Death can occur days or even weeks later.
- Relatively prevalent form of domestic violence
- Significant predictor for risk of future lethal violence. If your partner has strangled you in the past, your risk of being killed by them is 7x higher.

Download our Infographics





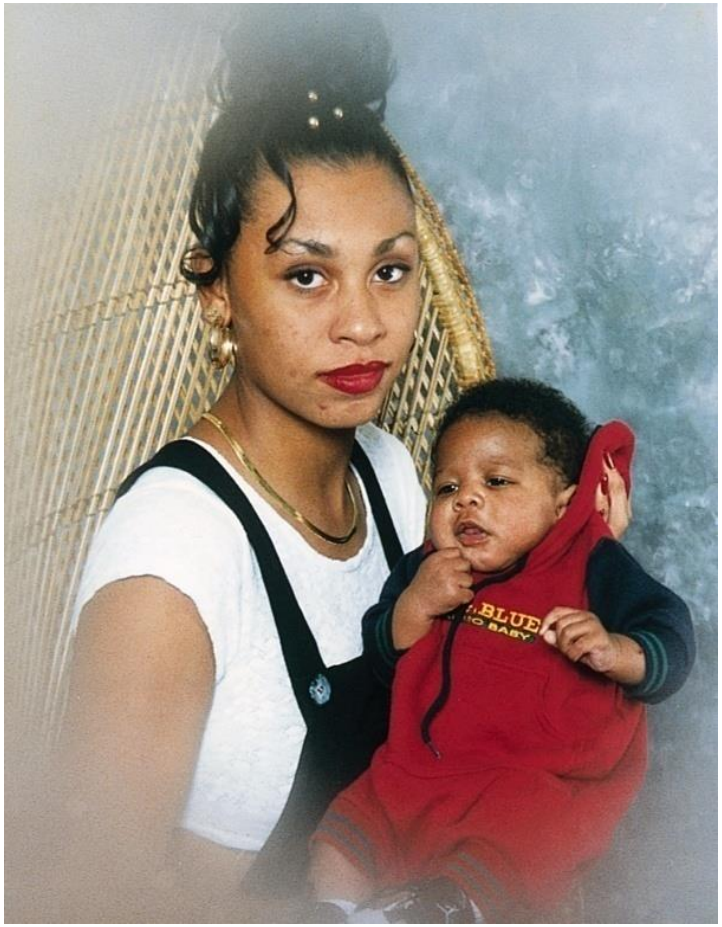
Training Institute on Strangulation Prevention

- Project of the Family Justice Center Alliance
- Launched October 2011
- Sponsored by the Office on Violence Against Women
- The leading training institute in the country on strangulation assaults
- Supported by a national board of advisors and faculty members
- www.strangulationtraininginstitute.com

Gael Strack, J.D.
CEO and Co-Founder

"Our study proved it – most victims of strangulation will not have visible external injuries. The lack of injuries and the lack of training caused the criminal justice system to minimize strangulation. We failed victims. But now we know – it's lethal and has serious immediate and long-term health consequences."

Why Our Work Started in 1995: Casondra Stewart and Tamara Smith



Journal of Emergency Medicine in 2001 Published Six Articles on Strangulation

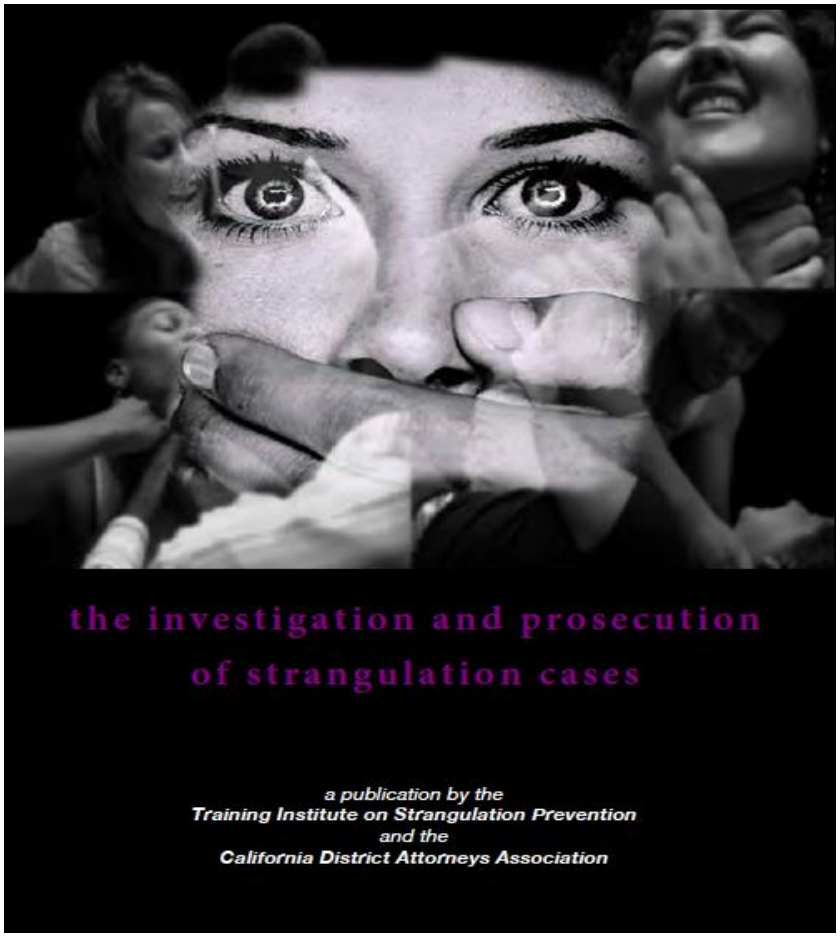
1 – Walking and Talking Victims
2 – Survey Results of Strangled Women
3 – Review of 300 Cases – Legal Issues
4 – Review of 300 Cases – Clinical Eval
5 – Review of 300 Cases – Fatal Cases
6 – Effect of Multiple Strangulation Attacks

Results of Focus Groups – Aug 2015 & Sept 2016

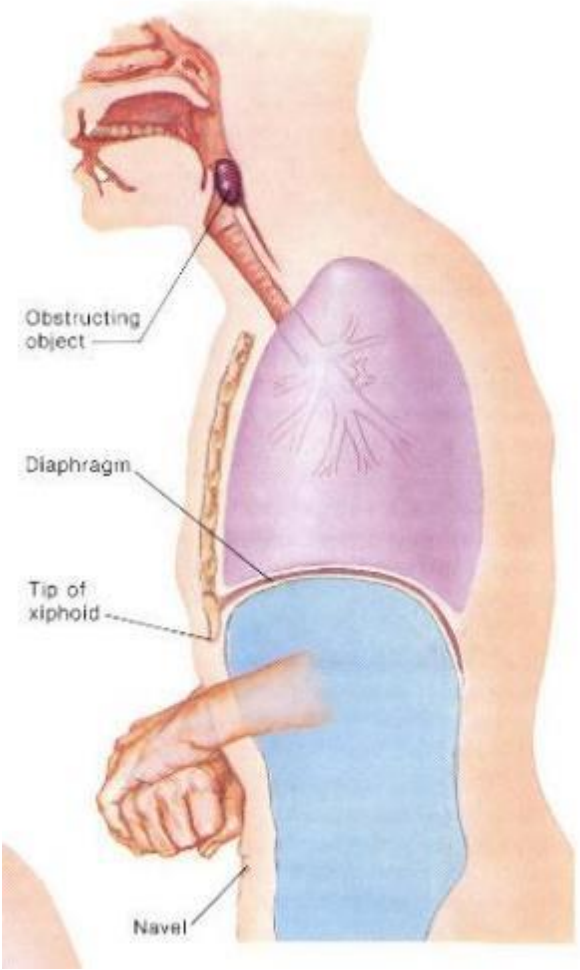
- Victims don't understand the impact of strangulation
  - "I never knew when I passed out I suffered a brain injury"
- Professionals need to ask
  - "No one told me"
- Professionals need to be educated
  - "If someone told me, I would have left sooner"
- Strangulation is not treated seriously
  - "They only charged a misdemeanor"
- Victims are suffering long term consequences
  - Thyroid Storm & Early Dementia
  - Spending thousands of dollars in medical costs trying to figure out what's wrong

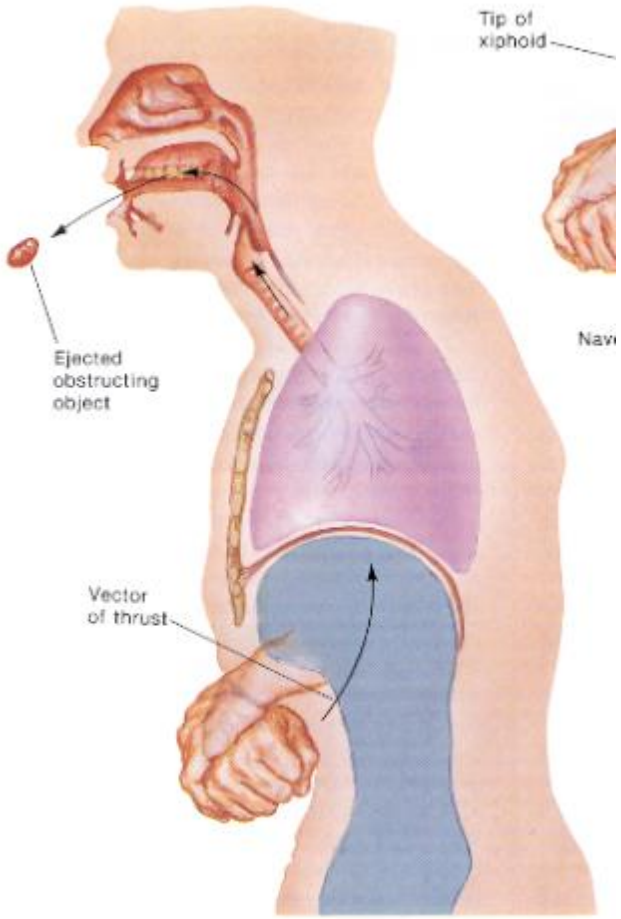
Alliance Publishes First Manual on Strangulation

- IPV Strangulation Crimes
- IPV Strangulation Crimes Manual – Developed by the National Family Justice Center Alliance/Training Institute on Strangulation Prevention
- In Partnership with the California District Attorneys Association
- Manual includes chapters on advocacy, investigations, prosecution, and legislation, among other topics



Strangulation is not “CHOKING”

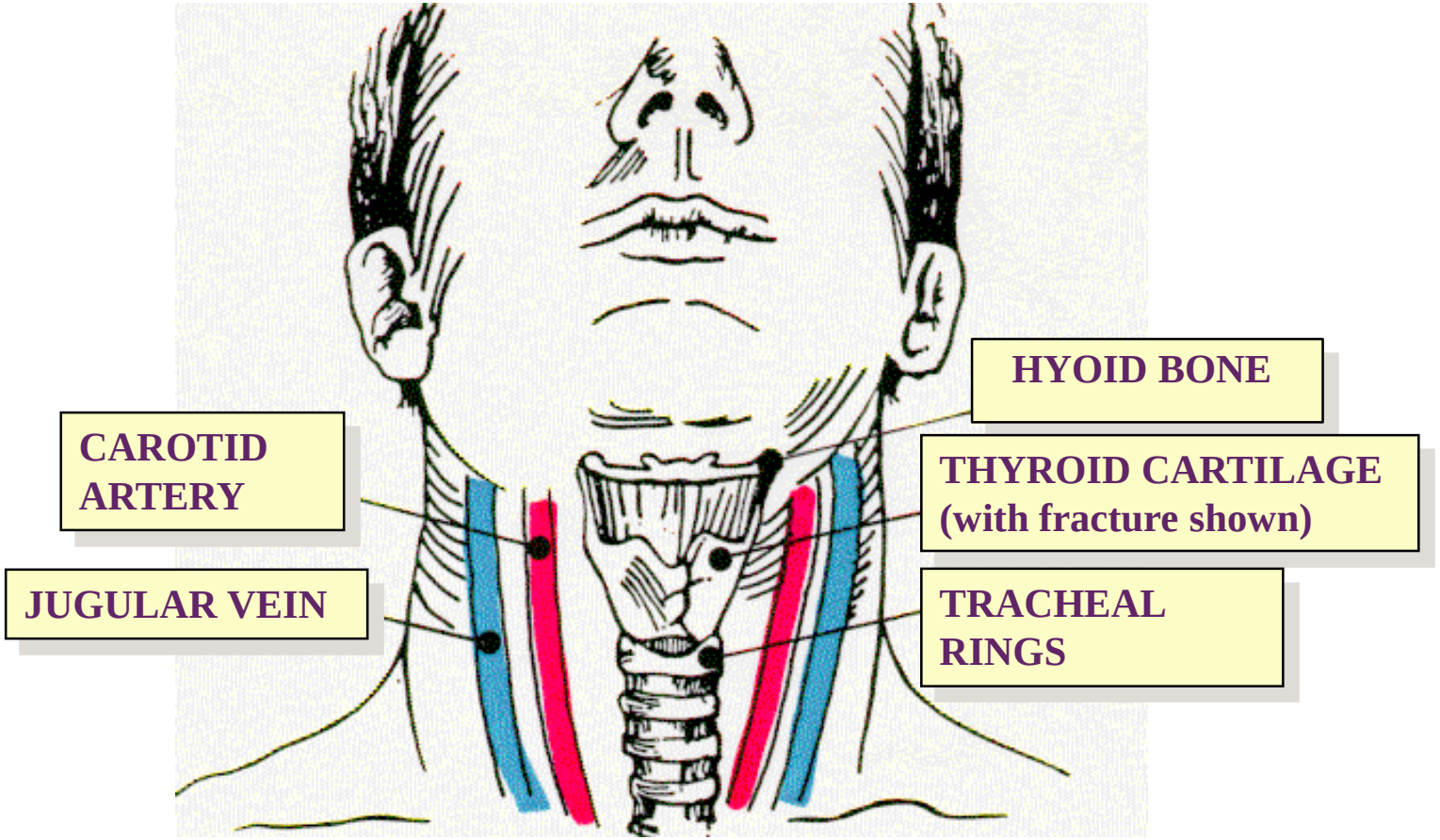




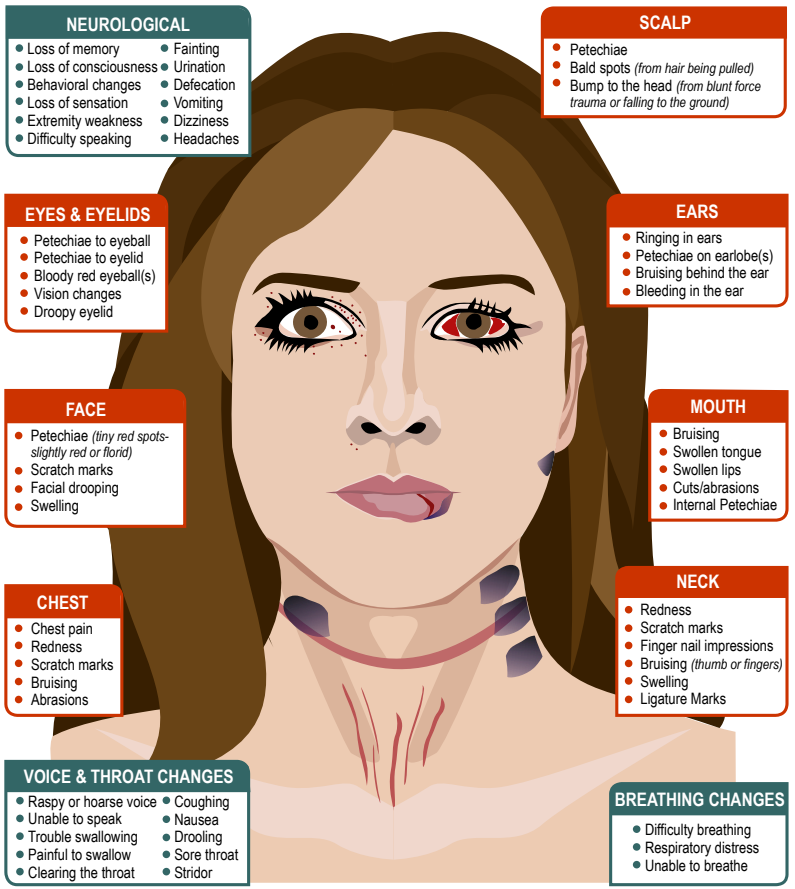
Definition

Strangulation is a form of asphyxia characterized by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck

Vessels: Arteries & Veins



SIGNS AND SYMPTOMS OF STRANGULATION



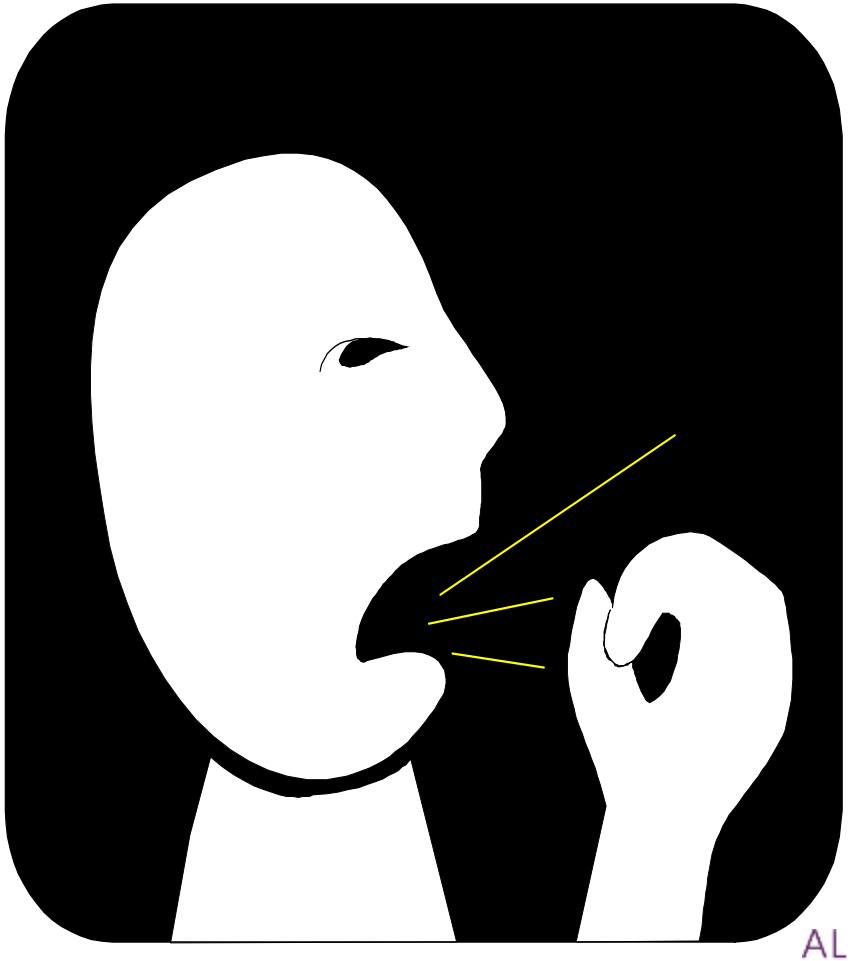
Source: *Strangulation in Intimate Partner Violence, Chapter 16, Intimate Partner Violence. Oxford University Press, Inc. 2009.*

TRAINING INSTITUTE on STRANGULATION PREVENTION

Graphics by Yesenia Aceves

www.strangulationtraininginstitute.com

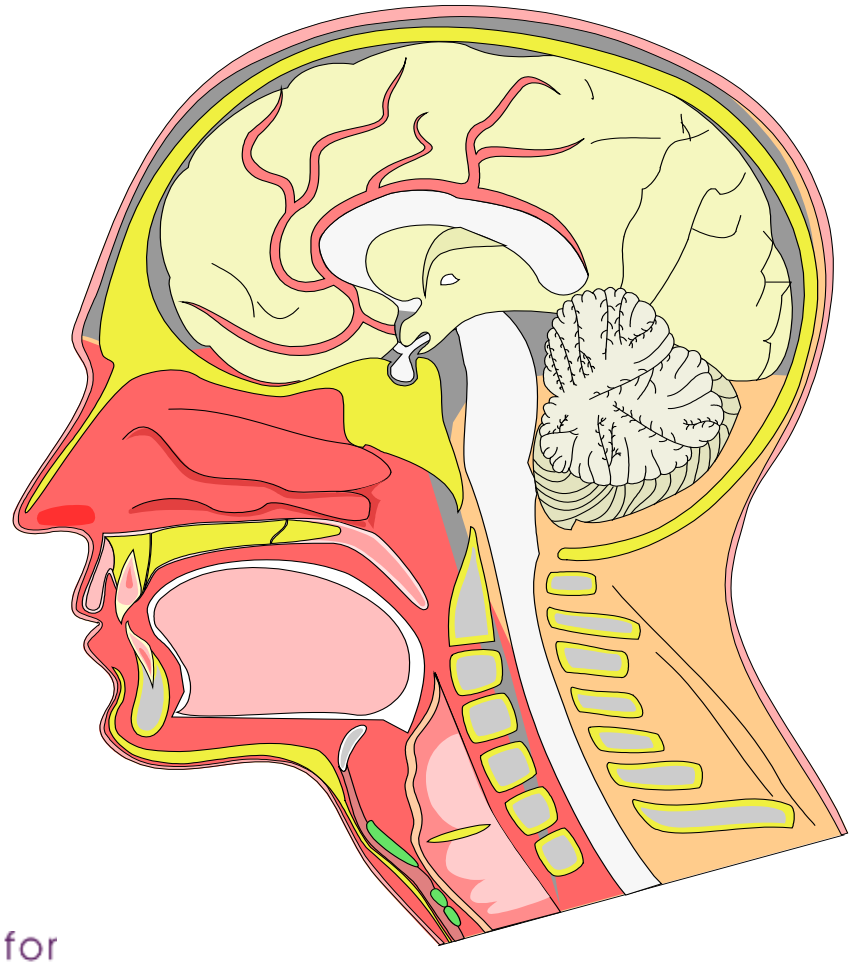
Symptoms of Laryngeal Injury



- Voice changes
  - 50% of victims
  - Nerve (recurrent laryngeal nerve)
  - Hoarseness (dysphonia)
    - May be permanent
  - Loss of voice (aphonia)

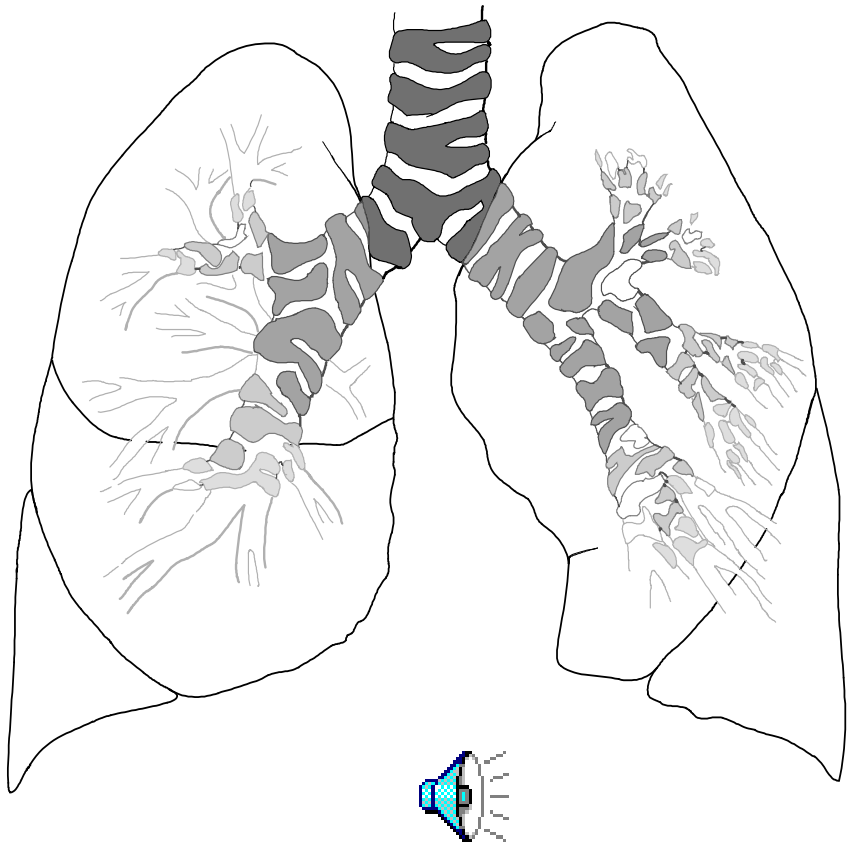
Symptoms of Laryngeal Injury

- Swallowing Changes
  - Due to larynx injury
  - Difficult to swallow (dysphagia)
  - Painful to swallow (odynophagia)



Symptoms of Laryngeal Injury

- Breathing Changes
  - Due to laryngeal fracture or swelling
  - Difficult to breathe (dyspnea)
  - Inability to breathe (apnea)
  - May appear mild but may kill within 36 hours



Symptoms of (Asphyxia or Hypoxia)

- Behavorial Changes
  - Early: Restlessness and violence
    - Hostile toward officers at the scene
    - “She woke up fighting”
  - Long term:
    - Psychosis
    - Amnesia
    - Changes in personality
    - Progressive dementia

Symptoms of (Asphyxia or Hypoxia)

- Evidence of brain Injury from strangulation will include problems with:
  - Memory
  - Concentration
  - Sleep
  - Headaches
  - Depression and
  - Anxiety

Lethal Progression

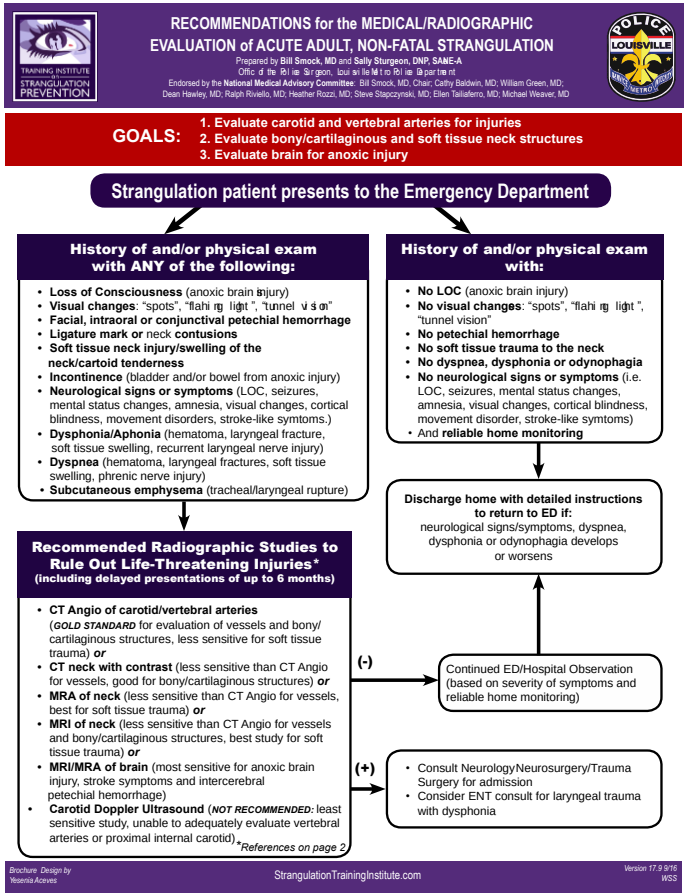
- 6.8 seconds – unconscious (brain cells begin to die)
- 15+ seconds – loss of bladder control
- 30+ seconds – loss of bowel control
- ?? seconds – point of no return
- Amount of brain cell death will depend on location of oxygen deprivation in the brain, length of unconsciousness, age, intoxication, prior anoxic episodes.
- ? Minutes – death (no controlled human studies)

Evidence of Alterations of Consciousness = Anoxic Injury

Brain Injury in Battered Women, Journal of Consulting and Clinical Psychology, 2003, Vol. 71, No. 4, 797-804

- A period of dizziness
- Felt stunned or disoriented
- Seen stars or spots (visual impairment)
- Loss of consciousness or blacked out
- Loss of memory
- Standing up one minute then waking up on the floor
- Bowel or bladder incontinence
- Unexplained bump on head

Special Thanks to LMPD, Dr. Smock & National Advisory Board



RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by **Bill Smock, MD** and **Sally Sturgeon, DNP, SANE-A**

Office of the Medical Examiner, Louisville Metro Police Department

Endorsed by the **National Medical Advisory Committee**: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Riviello, MD; Heather Rozzi, MD; Steve Stapczynski, MD; Ellen Taliaferro, MD; Michael Weaver, MD

GOALS:
1. Evaluate carotid and vertebral arteries for injuries
2. Evaluate bony/cartilaginous and soft tissue neck structures
3. Evaluate brain for anoxic injury

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:

- **Loss of Consciousness** (anoxic brain injury)
- **Visual changes**: "spots", "flashing light", "tunnel vision"
- **Facial, intraoral or conjunctival petechial hemorrhage**
- **Ligature mark or** neck **contusions**
- **Soft tissue neck injury/swelling of the neck/cartoid tenderness**
- **Incontinence** (bladder and/or bowel from anoxic injury)
- **Neurological signs or symptoms** (LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symtoms.)
- **Dysphonia/Aphonia** (hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
- **Dyspnea** (hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
- **Subcutaneous emphysema** (tracheal/laryngeal rupture)

History of and/or physical exam with:

- **No LOC** (anoxic brain injury)
- **No visual changes**: "spots", "flashing light", "tunnel vision"
- **No petechial hemorrhage**
- **No soft tissue trauma to the neck**
- **No dyspnea, dysphonia or odynophagia**
- **No neurological signs or symptoms** (i.e. LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorder, stroke-like symtoms)
- And **reliable home monitoring**

Discharge home with detailed instructions to return to ED if: neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens

Recommended Radiographic Studies to Rule Out Life-Threatening Injuries* **(including delayed presentations of up to 6 months)**

- **CT Angio of carotid/vertebral arteries** (***GOLD STANDARD*** for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) ***or***
- **CT neck with contrast** (less sensitive than CT Angio for vessels, good for bony/cartilaginous structures) ***or***
- **MRA of neck** (less sensitive than CT Angio for vessels, best for soft tissue trauma) ***or***
- **MRI of neck** (less sensitive than CT Angio for vessels and bony/cartilaginous structures, best study for soft tissue trauma) ***or***
- **MRI/MRA of brain** (most sensitive for anoxic brain injury, stroke symptoms and intercerebral petechial hemorrhage)
- **Carotid Doppler Ultrasound** (***NOT RECOMMENDED:*** least sensitive study, unable to adequately evaluate vertebral arteries or proximal internal carotid)

*References on page 2

(-) Continued ED/Hospital Observation (based on severity of symptoms and reliable home monitoring)

(+)
- Consult NeurologyNeurosurgery/Trauma Surgery for admission
- Consider ENT consult for laryngeal trauma with dysphonia

Brochure Design by Yesenia Acevez

StrangulationTrainingInstitute.com

Version 17.9 9/16 WSS

Short & Long Term Consequences

- Hypoxia/Anoxia – short term
- Anoxic Brain Injury
- Traumatic Brain Injury – blow to the Head
- Concussion
- PTSD
- Carotid Dissection
- Delayed Death

STRANGULATION
ASSESSMENT CARD

SIGNS

- Red eyes or spots (Petechiae)
- Neck swelling
- Nausea or vomiting
- Unsteady
- Loss or lapse of memory
- Urinated
- Defecated
- Possible loss of consciousness
- Ptosis – droopy eyelid
- Droopy face
- Seizure
- Tongue injury
- Lip injury
- Mental status changes
- Voice changes

SYMPTOMS

- Neck pain
- Jaw pain
- Scalp pain (from hair pulling)
- Sore throat
- Difficulty breathing
- Difficulty swallowing
- Vision changes (spots, tunnel vision, flashing lights)
- Hearing changes
- Light headedness
- Headache
- Weakness or numbness to arms or legs
- Voice changes

CHECKLIST

S **Scene & Safety.** Take in the scene. Make sure you and the victim are safe.

T **Trauma.** The victim is traumatized. Be kind. Ask: what do you remember? See? Feel? Hear? Think?

R **Reassure & Resources.** Reassure the victim that help is available and provide resources.

A **Assess.** Assess the victim for signs and symptoms of strangulation and TBI.

N **Notes.** Document your observations. Put victim statements in quotes.

G **Give.** Give the victim an advisal about delayed consequences.

L **Loss of Consciousness.** Victims may not remember. Lapse of memory? Change in location? Urination? Defecation?

E **Encourage.** Encourage medical attention or transport if life-threatening injuries exist.

TRANSPORT

If the victim is **Pregnant** or has life-threatening injuries which include:

- Difficulty breathing
- Difficulty swallowing
- Petechial hemorrhage
- Vision changes
- Loss of consciousness
- Urinated
- Defecated

DELAYED CONSEQUENCES

Victims may look fine and say they are fine, but just underneath the skin there would be internal injury and/or delayed complications. Internal injury may take a few hours to be appreciated. The victim may develop delayed swelling, hematomas, vocal cord immobility, displaced laryngeal fractures, fractured thyroid bone, airway obstruction, stroke or even delayed death from a carotid dissection, bloodclot, respiratory complications, or anoxic brain damage.

Tallaferro, E., Hawley, D., McClane, G.E. & Strack, G. (2009), Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective.* Oxford University Press, Inc.

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ADVISAL TO PATIENT

- After a strangulation assault, you can experience internal injuries with a delayed onset of symptoms, usually within 72 hours. These internal injuries can be serious or fatal.
- Stay with someone you trust for the first 24 hours and have them monitor your signs and symptoms.
- Seek medical attention or call 911 if you have any of the following symptoms: difficulty breathing, trouble swallowing, swelling to your neck, pain to your throat, hoarseness or voice changes, blurred vision, continuous or severe headaches, seizures, vomiting or persistent cough.
- The cost of your medical care may be covered by your state's victim compensation fund. An advocate can give you more information about this resource.
- The National Domestic Violence Hotline number is **1-888-799-SAFE**.

NOTICE TO MEDICAL PROVIDER

- The Medical Advisory Board of the Training Institute on Strangulation Prevention has developed recommendations for the radiologic evaluation of the adult strangulation victim. In patients with a history of a loss of consciousness, loss of bladder or bowel control, vision changes or petechial hemorrhage the medical provider must evaluate the carotid and vertebral arteries, bony/cartilaginous and soft tissue neck structures and to the brain for injuries. The recommendations with the medical references is available at www.strangulationtraininginstitute.com
- Life-threatening injuries include evidence of petechial hemorrhage, loss of consciousness, urination, defecation and/or visual changes. If your patient exhibits any of the above symptoms, medical/radiographic evaluation is strongly recommended. Radiographic testing should include: a CT angiography of carotid/vertebral arteries (most sensitive and preferred study for vessel evaluation) or CT neck with contrast, or MRA/MRI of neck and brain.
- ED/Hospital observation should be based on severity of symptoms and reliable home monitoring.
- Consult Neurology, Neurosurgery and/or Trauma Surgery for admission.
- Consider an ENT consult for laryngeal trauma with dysphonia, odynophagia, dyspnea.
- Discharge home with detailed instructions to return to ED if neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens.

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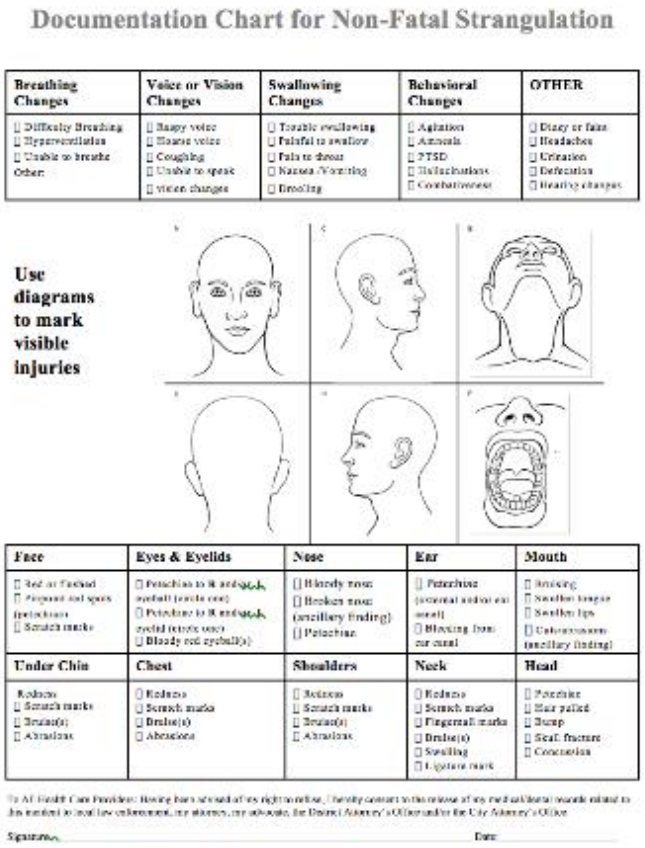
Utilize Specialized Documentation Forms for Non-Fatal Strangulation



Documentation Chart for Non-Fatal Strangulation

Breathing Changes	Voice or Vision Changes	Swallowing Changes	Behavioral Changes	OTHER
☐ Difficulty Breathing ☐ Hyperventilation ☐ Unable to breathe Other:	☐ Raspy voice ☐ Hoarse voice ☐ Coughing ☐ Unable to speak ☐ vision changes	☐ Trouble swallowing ☐ Painful to swallow ☐ Pain to throat ☐ Nausea /Vomiting ☐ Drooling	☐ Agitation ☐ Amnesia ☐ PTSD ☐ Hallucinations ☐ Combativeness	☐ Dizzy or faint ☐ Headaches ☐ Urination ☐ Defecation ☐ Hearing changes

Use diagrams to mark visible injuries

Face	Eyes & Eyelids	Nose	Ear	Mouth
☐ Red or Flushed ☐ Petechiae and spots (petechiae) ☐ Scratch marks	☐ Petechiae to R and/or L eyeball (circle one) ☐ Petechiae to R and/or L eyelid (circle one) ☐ Bloody red eyeball(s)	☐ Bloody nose ☐ Broken nose (ancillary finding) ☐ Petechiae	☐ Petechiae (external and/or ear canal) ☐ Bleeding from ear canal	☐ Bruising ☐ Swollen tongue ☐ Swollen lips ☐ Unconsciousness (ancillary finding)
Under Chin	**Chest**	**Shoulders**	**Neck**	**Head**
☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Fingernail marks ☐ Bruise(s) ☐ Swelling ☐ Ligature mark	☐ Petechiae ☐ Hair pulled ☐ Bump ☐ Scalp fracture ☐ Concussion

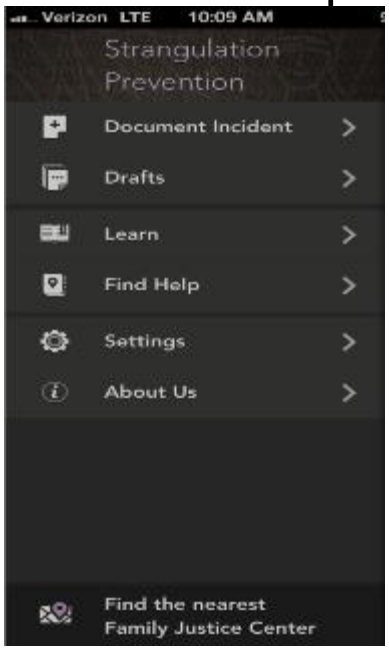
To All Health Care Providers: Having been advised of my right to refuse, I hereby consent to the release of my medical/dental records related to this incident to local law enforcement, city attorney, city advocate, the District Attorney's Office and/or the City Attorney's Office.

Signature: _____ Date: _____

Updated, Enhanced iPhone APP

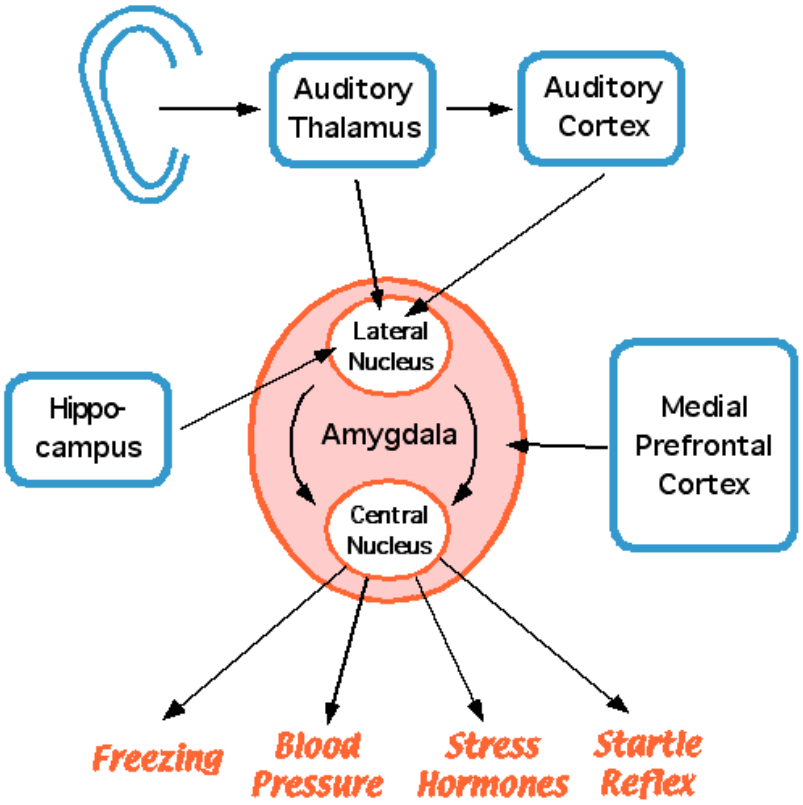
“Document It”

A Mobile App to Document Non-Fatal Strangulation Cases
The mobile application will assist professionals from ***all disciplines*** and individuals who are “choked” by an intimate partner to document multiple incidents using:

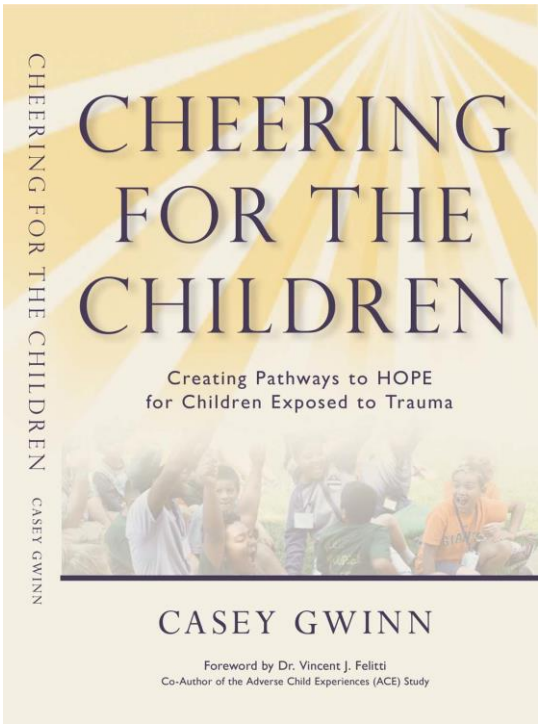


- Photo, Video, and Audio capture
- User-friendly survey of possible symptoms and injuries
- Text area to tell the story of the incident
- Signed consent of release of information; and
- Ability to send a full report to law enforcement

Better Understand Trauma



- Trauma may impact a victim's ability to accurately describe details and chronology


CHEERING FOR THE CHILDREN
CASEY GWINN
CHEERING FOR THE CHILDREN
Creating Pathways to HOPE
for Children Exposed to Trauma
CASEY GWINN
Foreword by Dr. Vincent J. Felitti
Co-Author of the Adverse Child Experiences (ACE) Study

What Professionals Need to Know about Strangulation when Working with Deaf Victims

- Dr. Cindi Cassady

The Important Connection between Deaf Women and Strangulation

- Many deaf children experience physical and sexual abuse growing up. This can have a “normalizing” effect on subsequent abuse by intimate partners.
- Lack of sign language & effective communication at home leads to lack of awareness and understanding about abuse and abusive relationships.
- Lack of exposure to or understanding of written and spoken materials on GBV and DV –preferred method of delivery of information is in ASL.
- Lack of descriptive and conceptual understanding for what constitutes “ real abuse” in the Deaf community. One person’s “abuse” may not be worthy of being considered another Deaf person’s abuse. This results in minimization and denial of the severity of physical and sexual abuse.

Strangulation Interview

- The physical environment is important
  - Good lighting
  - Quiet without visual distractions
  - Use well-lit private office where perpetrator cannot oversee conversation.
  - Professional interpreter
  - At the scene, do not use the person who can talk to tell what happened. Could be the abuser.

- http://www.victimsofcrime.org/docs/2011

Questions and Form have been Created by the Training Institute but How do you use Them with Working with Deaf Victims?

Interview

- How long?- Hawley/Agnew advices having the victim/survivor close their eyes and tell you “when” to indicate how long the suspect applied pressure to her neck. This will require that you have an interpreter explain that by closing their eyes, and thinking back to the experience, it will help with the length of time she experienced being strangled. The woman may be very reluctant to close her eyes as she has been traumatized and depends on her vision to feel safe and know what is happening around her since she is deaf. (Hawley & Heisler, 2012)
- What stopped the perpetrator from continuing to strangle you?- Deaf person will not know if the perpetrator heard someone and then stopped.
- Does their voice sound different-for a deaf person this question should relate to how their voice feels rather than how it sounds. Does it feel raspy, or feel difficult to use their voice, does it hurt to swallow?

Interview

- Symptoms related to dizziness: Deaf people often have tinnitus, Meniere's, vertigo. So experiencing feelings of being off-balance, dizziness, ring in the ears, etc. may not seem abnormal or unusual to them and may go unreported unless asked about specifically.
- Interviewer should inquire if the Deaf person has ever experienced ringing in their ears or vertigo (dizziness) before the strangulation incident(s).
- It is critical to refer for medical help if the person experienced any of the following (Hawley, McClane, Taliaferro 2001; McLean, 2012):

- 1. Difficulty or changes in breathing
- 2. Increased throat or neck pain
- 3. Difficulty swallowing
- 4. Change in level of consciousness
- 5. Nausea and vomiting
- 6. Vision changes
- 7. Difficulty speaking notice changes in how it feels when they use their voice, or other people report a change in their voice.
- 8. Left or right sided weakness
- 9. Psychological changes/suicidal thoughts.

Everyone Should be Asking “The Question”

- Ask the question in a variety of ways:
- Does he put his/her hands around your throat?
- Does he squeeze your throat?
- Does he “choke” you during sex?
- Does he put a hand on your throat to intimidate?
- Does he control or silence you by holding you by your throat?
- Does he push you against the wall/floor when he has a hand/arm on your
- throat?

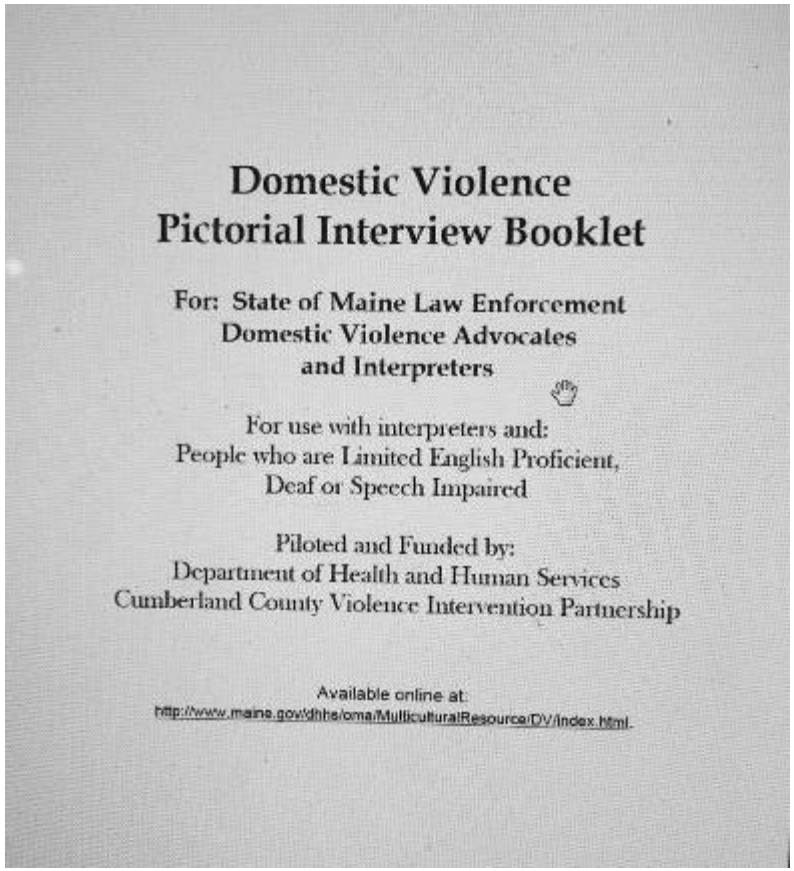
Best Practices for Follow-Up

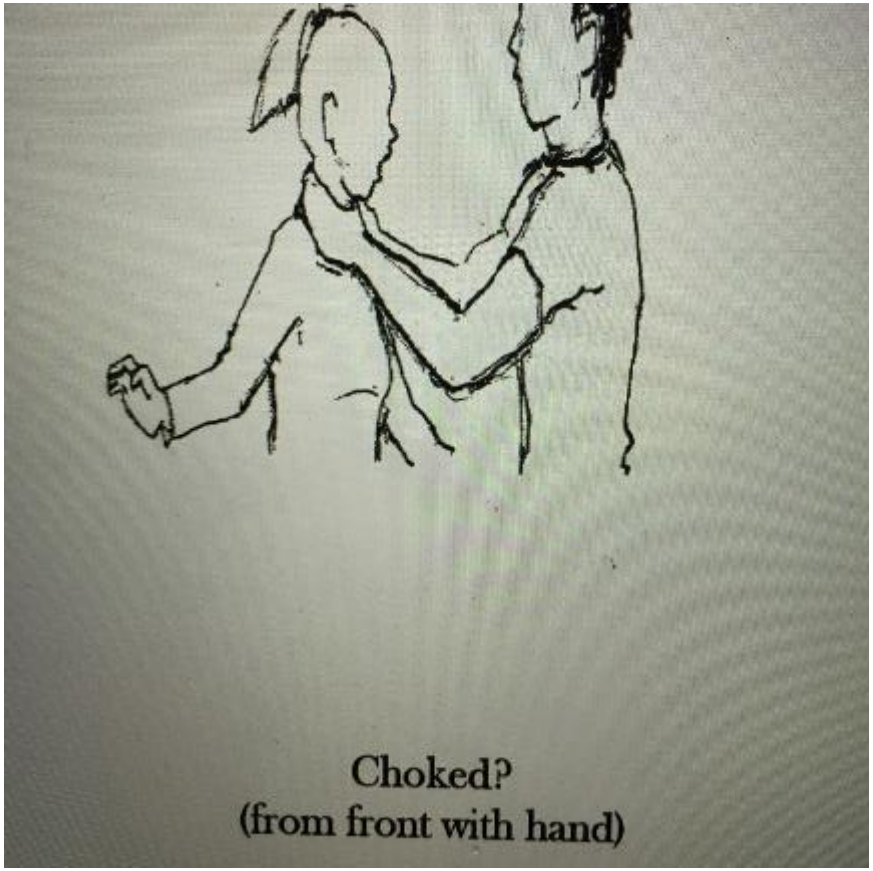
- Every victim of any type of abuse should be asked whether they have been strangled/choked.
- Strangulation occurs in relationships other than Intimate partner
- Strangulation is intergenerational
- Victims benefit from being informed (McLean, 2014)

Visual aids

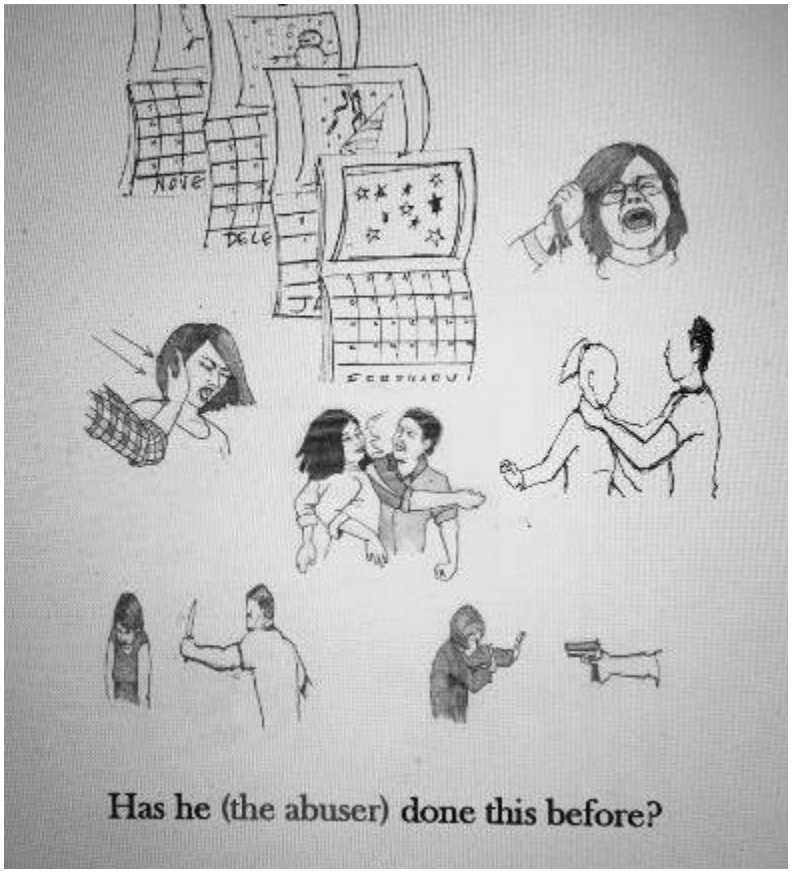
- If the Deaf woman has minimal sign language skills, it is imperative to use drawings to get a clear idea of what happened. (Domestic Violence Pictorial Interview Booklet, 2006)
- The use of medical terminology will need to be carefully explained and interpreted to the Deaf person who may have no understanding of the anatomy involved or terminology such as “defecated.”

Nonverbal Picture Cards

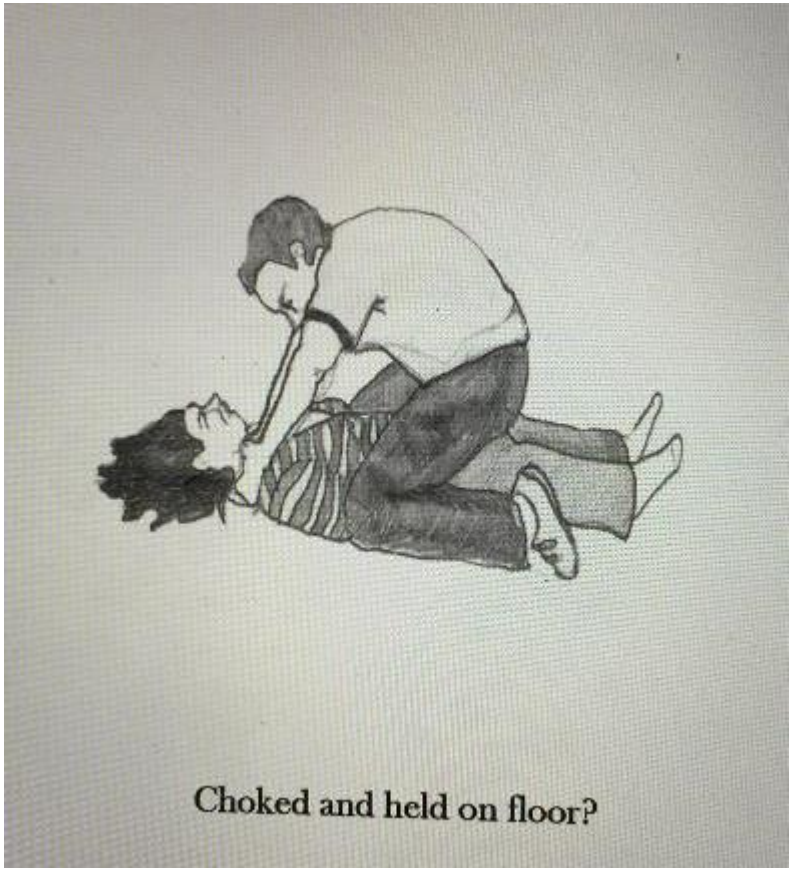


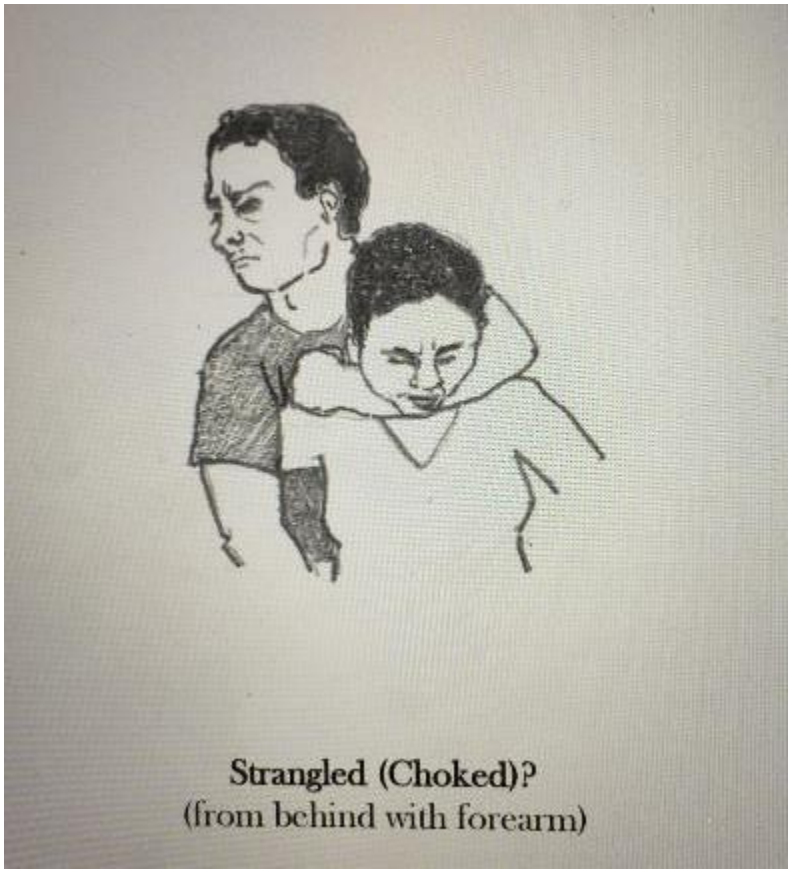


Nonverbal Picture Cards

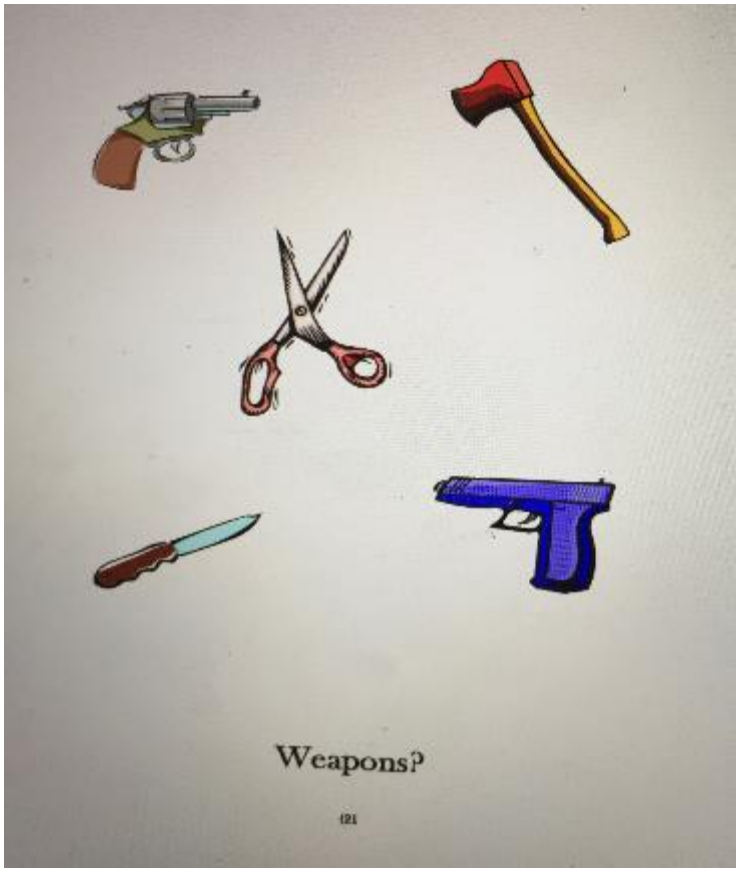


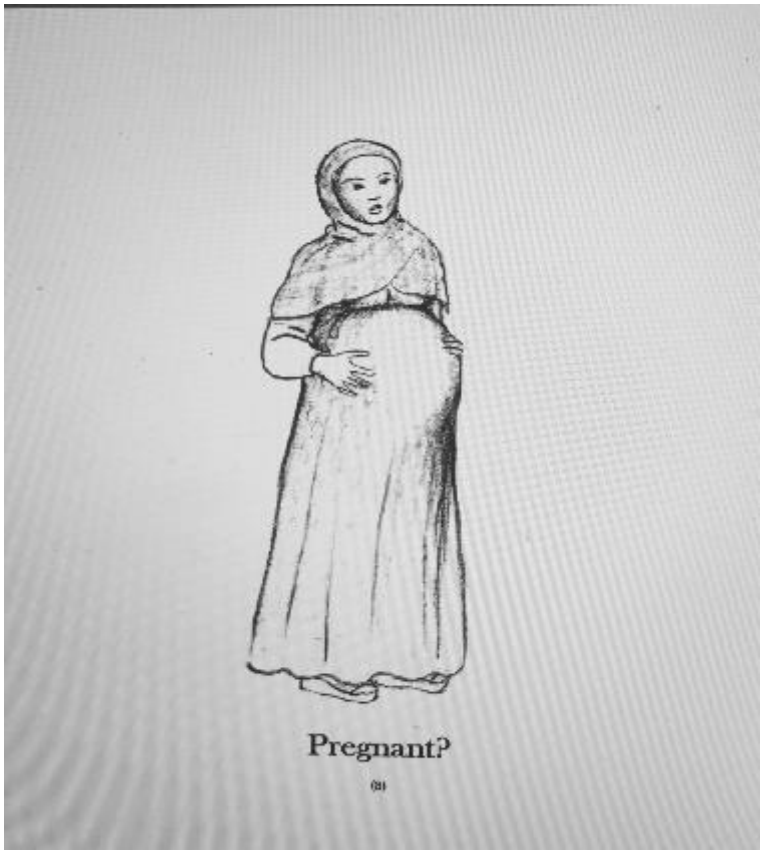
Nonverbal Picture Cards





Nonverbal Picture Cards





Recommendations for FJCs, Advocates & Service Providers

- Recognize Deaf as a distinct cultural and linguistic group. (Vera, 2014)
- Dedicate resources to address domestic and sexual violence in the Deaf community.(Vera, 2014)
- Prioritize Deaf expertise.(Vera, 2014)
- Fill research gaps-More research in the following three priority areas is required: (1) incidence and prevalence of domestic and sexual violence against Deaf individuals; (2) utilization of victim services and criminal justice system interventions; and (3) evaluations of Deaf-specific programs and other promising approaches to serving Deaf survivors.(Vera, 2014)
- Collect date on Deaf cultural status: Gathering data about Deaf cultural status, like other diversity data, is essential to understanding these survivors' needs and planning services to meet them. (Vera Institute of Justice: Culture, Language, and Access: Key Considerations for Serving Deaf Survivors, 2014)

National & International Research

- National Level- there is little if any research that has been done specifically looking at the Deaf community and strangulation. The rate of occurrence of strangulation during intimate partner violence or any specifics related to this type of potentially lethal violence, are virtually unknown for the Deaf and hard of hearing populations.
- International Level- There is no data that has looked at the rate of incidence of lethal or attempted strangulation in Deaf communities in developing countries.
- The Alliance for Hope will partner with the Univ. of Kibungo in Rwanda to begin a seminal, cross-cultural study comparing the rate of attempted strangulation in Deaf and hearing women in Malawi and Rwanda.

Why Research is Important

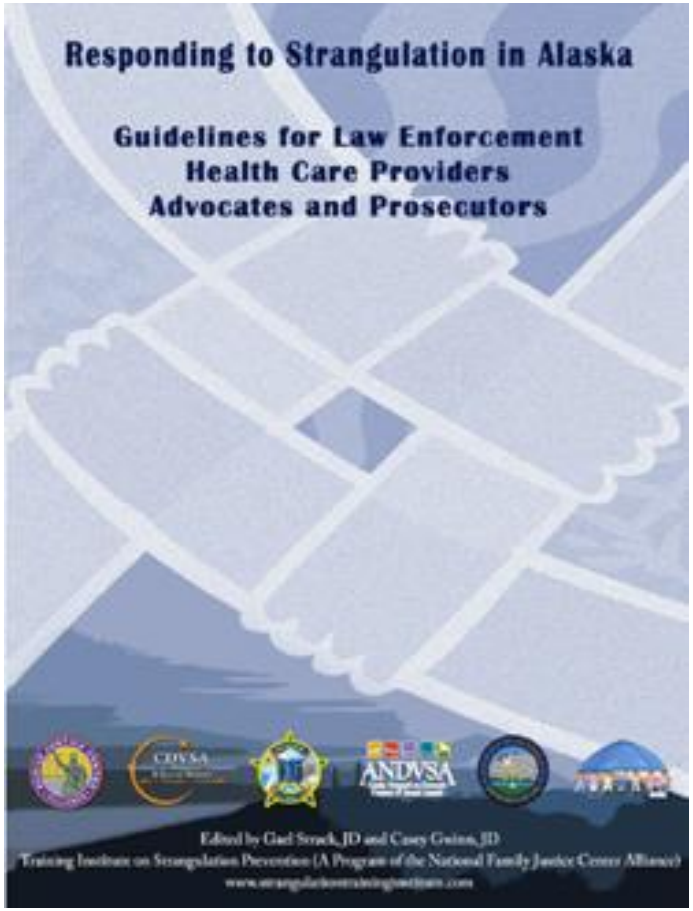
- Especially in developing countries at the international level, we need to gather data in order to begin to educate the medical and legal systems as well as deaf and hearing women themselves, about the significant lethality associated with strangulation and domestic violence.
- We need to collaborate with experts in the Deaf community both nationally and internationally to engage Deaf individuals to learn more about what different types of abuse look like and to not minimize their experience of abuse even in countries where abuse of women is “culturally acceptable.”

Resources from the Training Institute on Strangulation Prevention

www.strangulationtraininginstitute.com

Alaska Strangulation Manual

- New Chapters
- Children
- Elders
- Community Based Advocacy



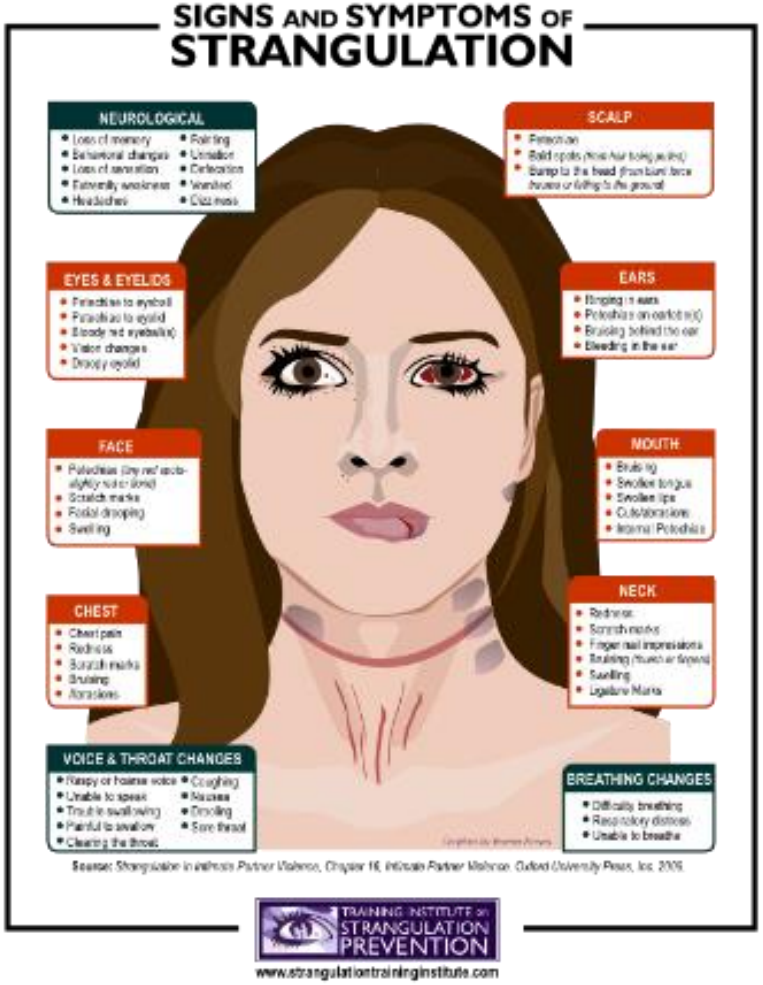
New Chapter on Elder Strangulation
Dr. Dean Hawley and Candace Heisler

- Strangulation as the cause of death increases in frequency with the victim's age.
- Strangulation actually becomes more difficult to detect in death investigations of older adults.
- Higher percentage of elders die as a result of strangulation – 33% vs. 10% general population

DV Report – A Nice Short Summary Special thanks to Kelly Weisberg

- Available without a subscription
- www.civicresearchinstitute.com/pdfs/DVR1906.pdf

Esperanza – materials in Spanish



Victim Brochure (front)

STRANGULATION

Strangulation has only recently been identified as one of the most lethal forms of domestic violence: ***unconsciousness may occur within seconds and death within minutes.*** When domestic violence perpetrators choke (strangle) their victims, not only is this a felonious assault, but it may be an attempted homicide. Strangulation is an *ultimate form of power and control*, where the batterer can demonstrate control over the victim's next breath; having devastating psychological effects or a potentially fatal outcome.

Sober and conscious victims of strangulation will first feel terror and severe pain. *If strangulation persists, unconsciousness will follow.* Before lapsing into unconsciousness, a strangulation victim will usually resist violently, often producing injuries of their own neck in an effort to claw off the assailant, and frequently also producing injury on the face or hands to their assailant. These defensive injuries may not be present if the victim is physically or chemically restrained before the assault.

Observation of the changes in these signs over time can greatly facilitate determination of the nature and scope of internal damage produced during assault, and lend credibility to witness accounts of the force and duration of the assault.

OBSERVING CHANGES

Documentation by photographs sequentially for a period of days after the assault is very helpful in establishing a journal of physical evidence.

Victims should also seek medical attention if they experience difficulty breathing, speaking, swallowing or experience nausea, vomiting, lightheadedness, headache, involuntary urination and/or defecation.

Although most victims may suffer no visible injuries whatsoever and many fully recover from being strangled, all victims, especially pregnant victims, should be encouraged to seek immediate medical attention. A medical evaluation may be crucial in detecting internal injuries and saving a life.

LOSING CONSCIOUSNESS

Victims may lose consciousness by any one or all of the following methods: blocking of the carotid arteries in the neck (depriving the brain of oxygen), blocking of the jugular veins (preventing deoxygenated blood from exiting the brain), and closing off the airway, making breathing impossible.

Very little pressure on the carotid arteries and/or veins for ten seconds is necessary to cause unconsciousness. However, if the pressure immediately released, consciousness will be regained within ten seconds. To completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required. Brain death will occur in 4 to 5 minutes, if strangulation persists.

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STRANGULATIONTRAININGINSTITUTE.COM

FACTS VICTIMS OF STRANGULATION (CHOKING) NEED TO KNOW

Monitor Your SIGNS

Date & Time	Journal Your Signs

Monitor Your Symptoms

Date & Time	Journal Your Symptoms

Date & Time	Journal Any Other Sensation

Signs of Strangulation

Head- pinpoint red spots (petechiae) on scalp, hair pulled, bump(s), skull fracture, concussion.

Face- red or flushed, petechiae, scratch marks.

Eyes and Eyelids- petechiae to the left or right eyeball, bloodshot eyes.

Ear- petechiae (external and/or ear canal), bleeding from ear canal.

Nose- bloody nose, broken nose, petechiae.

Mouth- bruising, swollen tongue, swollen lips, cuts/abrasions.

Under the chin- redness, scratch marks, bruise(s), abrasions.

Neck- redness, scratch marks, fingernail impressions, bruise(s), abrasions, swelling, ligature marks.

Chest and Shoulders- redness, scratch marks, bruise(s), abrasions.

Symptoms of Strangulation

Voice changes- raspy and/or hoarse voice, coughing, unable to speak, complete loss of voice.

Swallowing changes- trouble swallowing, painful swallowing, neck pain, nausea/vomiting, drooling.

Breathing changes- difficulty breathing, hyperventilation, unable to breathe.

Behavioral changes- restlessness or combativeness, problems concentrating, amnesia, agitation, Post-traumatic Stress Syndrome, hallucinations.

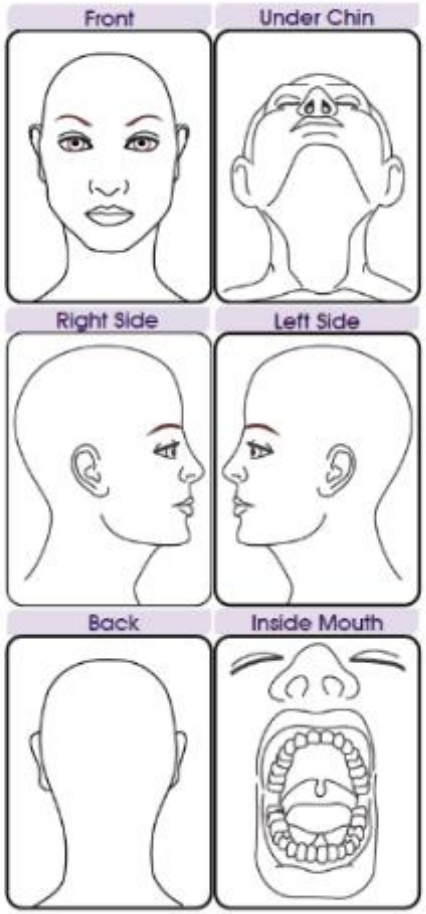
Vision changes- complete loss or black & white vision, seeing 'stars', blurry, darkness, fuzzy around the eyes.

Hearing changes- complete loss of hearing, gurgling, ringing, buzzing, popping, pressure, tunnel-like hearing.

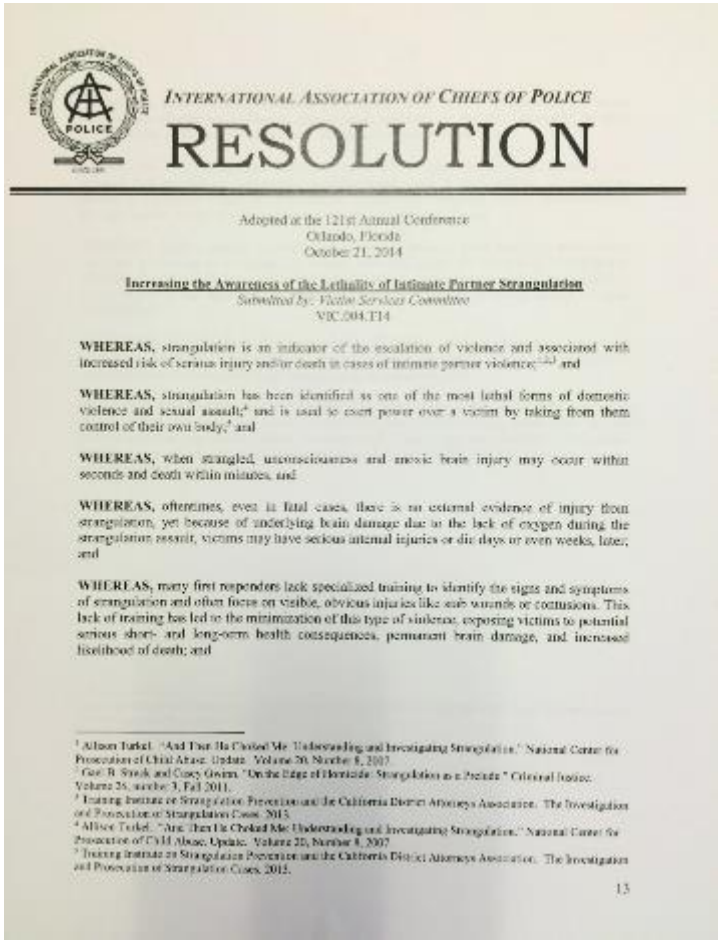
Other changes- Memory loss, unconsciousness, dizziness, headaches, involuntary urination or defecation, loss of strength, going limp.

Diagrams to Mark Visible Injuries

Use a pen or a marker to indicate any visble signs and/or symptoms.



Make Good use of IACP's Resolution 2014



INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE

RESOLUTION

Adopted at the 121st Annual Conference
Orlando, Florida
October 21, 2014

Increasing the Awareness of the Lethality of Intimate Partner Strangulation

Submitted by: Victim Services Committee
VSC.004.T14

WHEREAS, strangulation is an indicator of the escalation of violence and associated with increased risk of serious injury and/or death in cases of intimate partner violence;[1,2,3] and

WHEREAS, strangulation has been identified as one of the most lethal forms of domestic violence and sexual assault;[4] and is used to exert power over a victim by taking from them control of their own body;[5] and

WHEREAS, when strangled, unconsciousness and anoxic brain injury may occur within seconds and death within minutes; and

WHEREAS, oftentimes, even in fatal cases, there is no external evidence of injury from strangulation, yet because of underlying brain damage due to the lack of oxygen during the strangulation assault, victims may have serious internal injuries or die days or even weeks, later; and

WHEREAS, many first responders lack specialized training to identify the signs and symptoms of strangulation and often focus on visible, obvious injuries like stab wounds or contusions. This lack of training has led to the minimization of this type of violence, exposing victims to potential serious short- and long-term health consequences, permanent brain damage, and increased likelihood of death; and

[1] Allison Turkel. "And Then He Choked Me: Understanding and Investigating Strangulation." National Center for Prosecution of Child Abuse. Update. Volume 20, Number 8, 2007.
[2] Gael B. Strack and Casey Gwinn. "On the Edge of Homicide: Strangulation as a Prelude." Criminal Justice. Volume 26, number 3, Fall 2011.
[3] Training Institute on Strangulation Prevention and the California District Attorneys Association. The Investigation and Prosecution of Strangulation Cases. 2012.
[4] Allison Turkel. "And Then He Choked Me: Understanding and Investigating Strangulation." National Center for Prosecution of Child Abuse. Update. Volume 20, Number 8, 2007.
[5] Training Institute on Strangulation Prevention and the California District Attorneys Association. The Investigation and Prosecution of Strangulation Cases. 2012.

13

- Increasing Awareness of the Lethality of Intimate Partner Violence
- Strangulation is a felony or attempted homicide
- Support training, documentation forms, legislation and MDT

New IAFN Strangulation Position Paper and Recommendations (2016):

We recommend that:

- *1. Where possible, forensic nurses are utilized in collaboration with other providers to address the health care needs of the strangled patient population.*
- *2. Health care providers delivering emergency services receive training specific to the screening, medical and radiologic assessment, documentation, medical intervention, and follow-up care.*
- 3. *Health care providers caring for known or suspected sexual assault, intimate partner violence, elder abuse as well as child maltreatment victims should routinely screen for strangulation and understand the laws for reporting.*
- 4. *Health care agencies delivering emergency services should adopt evidence-based, multi-disciplinary policies and procedures that are current and well understood by staff in order to facilitate the screening, assessment and intervention process;*
- 5. *Health care agencies ensure consistent access to trained providers within the agency, as well as collaborative relationships with outside agencies (i.e. Law enforcement, advocacy and prosecution).*
- 6. *Health care providers that assess and treat strangulation patients include a detailed, strangulation-specific assessment as a standard component of the medical-forensic examination including protocols for medical/radiological evaluation danger assessment and safety planning (to be completed by medical or advocacy professionals)*.

Thank you

- Q & A
- www.strangulationtraininginstitute.com
- www.allianceforhope.com
- www.camphopeamerica.com

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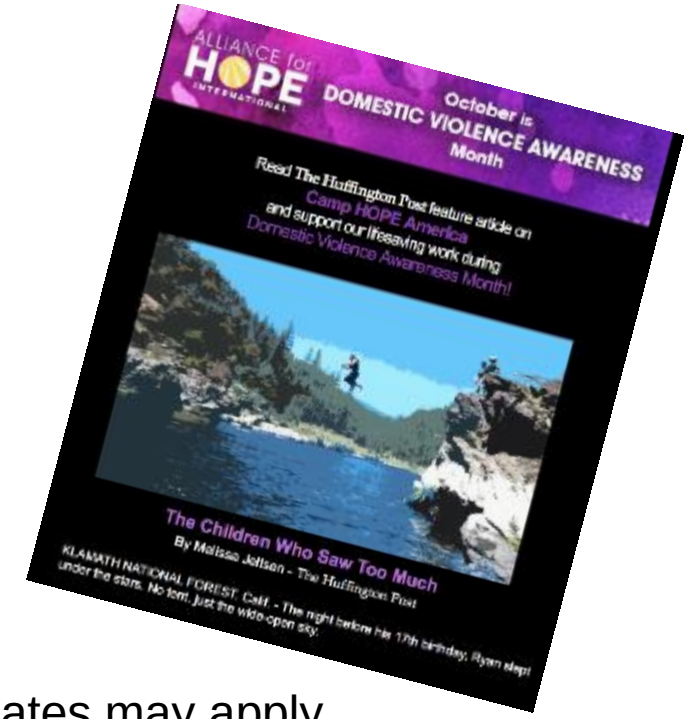

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Dr. Cindi Cassady is a Consultant/Lecturer at the University of Kibungo (UNIK) since 1st December 2015. As a consultant, she is designing and implementing a community based Clinical Psychology Training & Research Centre to provide comprehensive mental health services, psychodiagnostic and neuropsychodiagnostic assessment. The Centre will also serve as a training & research center for Rwandan and foreign psychologists and researchers. Dr. Cassady is tasked with re-designing the existing BA level Clinical Psychology department into a combined BA/MA Clinical psychology program which will include areas of specialization in gender-based violence, neuropsychology, drug and alcohol treatment & rehabilitation, early childhood development, marriage and family therapy.

Dr. Cassady received her BA with Honors in Social Psychology from Whittier College, Calif., USA in 1975; her M.A. in Clinical Psychology from the California School of Professional Psychology, Alliant University, CA, USA in 1979; and her Ph.D. in Clinical Psychology from the California School of Professional Psychology, Alliant University San Diego, CA, USA in 1982. She became a licensed Clinical Psychologist in 1984 after successfully passing the written and oral California Board Examination for psychologists. (Calif. Lic.1984; PSY 8504). In 2013, Dr. Cassady received her M.A. in Peace and Justice Studies, Emphasis: Conflict Resolution, Development and Human Rights from the Joan B. Kroc School of Peace Studies at the University of San Diego, San Diego, CA, USA.

For the past 32 years, Dr. Cassady has been a practitioner-scholar in the field of Clinical Psychology, specializing in working with gender based violence, child abuse and domestic violence victims and perpetrators. She has been Mental Health Director of two community- based organizations serving older adults, refugees and Deaf people seeking assistance with domestic violence related issues. For over 25 years, her private practice was dedicated to working with deaf adults and children who were victims of gender based violence, domestic violence and child abuse. She worked on the local, national and international level developing programs to address the gaps in mental health and psycho-social services for Deaf people and created programs that provided in American

Sign Language. Dr. Cassady was the founder and Director of an Adult Probation certified Deaf domestic violence perpetrator treatment group; one of two such programs in the US. from 2005 to 2013. Judges would court order perpetrators to attend the group as a way to divert and rehabilitate first-time male and female perpetrators.

Dr. Cassady trained judges, attorneys and police departments on legal and human rights issues with regard to Deaf people's rights to understand legal proceedings through the use of a certified sign language interpreter, and she supervised Masters level and Ph.D. level Clinical Psychology students from Gallaudet University, Washington D.C. and Alliant University, CA respectively, for their internships and post-doctoral licensing hours.

Since 2014, Dr. Cassady has provided weekly clinical supervision and training to the clinical psychologists at the Isange One Stop Centre in Kacyiru Police Hospital. From July 2010 to 2013, Isange One Stop Center received 6,246 GBV cases of which 4,499 cases (67.87%) are GVB cases and 1,747 (26.35%) are domestic violence cases. She recently developed an in-depth training module for Isange One Stop Centre clinical psychologists, medical staff and police, to teach risk assessment of IPV perpetrators, trauma informed treatment techniques with victims of GBV and the impact of psycho-educational rehabilitation programs on GBV perpetrators' rate of recidivism.

Certificate of Attendance

Webinar Training:
Intimate Partner Violence & Strangulation in the Deaf Community
Presented by Dr. Cindi Cassady

May 31, 2017
1.5 Training Hours

Gail Strack
Co-Founder and CEO
Alliance for HOPE International
Director, Training Institute on Strangulation Prevention