Improving Health Outcomes Through Violence Prevention: Phase II to Identify and Provide Brief Counseling on Intimate Partner Violence (IPV) in Health Centers

Addressing and Responding to Domestic and Sexual Violence in Healthcare Settings

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About this Adobe Connect Technology

- All participants are muted, press *6 to unmute.
- You may also use the text chat for comments.
- Slides and a link to the webinar recording will be emailed to all participants.
Webinar Agreements

• Because domestic and sexual violence (DSV) are so prevalent, assume that there are survivors among us.

• Be aware of your reactions and take care of yourself first.
At the end of this training, participants in attendance will be able to:

1. Define domestic and sexual violence (D/SV), reproductive coercion (RC) and sexual coercion (SC).

2. Describe the impact D/SV, RC, and SC on women’s health.

3. Describe how the CUES intervention can support immediate and long term safety and health outcomes for patients.

4. List two examples of how an intimate partner can interfere with a woman’s ability to use contraceptives successfully.
Domestic and Sexual Violence, Reproductive Coercion and Sexual Coercion: Definitions and Dynamics
Self Reflection: On a Scale of 1 to 5

1 being ‘not at all’ and 5 being ‘completely’

How comfortable are you assessing for domestic and sexual violence and responding to any disclosures?
One person in a relationship is using a *pattern* of methods and tactics to gain and maintain *power and control* over the other person.

- It is a cycle that gets worse over time – not a one time ‘incident’
- Abusers use jealousy, social status, mental health, money and other tactics to be controlling and abusive – not just physical violence
- Leaving an abusive relationship is not always the best, safest or most realistic option for survivors
Definitions of Domestic Violence

- Legal definitions are often more narrowly defined with particular focus on physical and sexual assault
- Public health definitions include a broader range of controlling behaviors that impact health including:
  - emotional abuse
  - social isolation
  - stalking
  - intimidation and threats
1 in 4 (25%) U.S. women report ever experiencing IPV.

(Source: 2010 CDC National Intimate Partner and Sexual Violence Survey)
1 in 5 women in U.S. has been raped at some time in their lives and half of them reported being raped by an intimate partner.

(Source: 2010 CDC National Intimate Partner and Sexual Violence Survey)
Male Victims

- 1 in 59 men have been raped in their lifetime.
- 1 in 7 men have been the victim of severe physical violence by an intimate partner.
- 1 in 19 men have been stalked during their lifetime.

(Source: 2010 CDC National Intimate Partner and Sexual Violence Survey)
LGBTQ Communities

- **61% of bisexual women** and **37% of bisexual men** experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

- **44% of lesbian women** and **26% of gay men** experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

- **Of transgender individuals, 34.6%** reported lifetime physical abuse by a partner and **64%** reported experiencing sexual assault.

(Breiding et al, 2011; Landers & Gilsanz, 2009)
Why might a woman stay in a relationship when domestic violence has occurred?
Considerations for Immigrant or non-English Speaking Survivors

Unique controlling behaviors:
- Threats of deportation
- Taking kids outside the U.S.
- Lying about immigration status
- Forbidding English classes
- Using language privilege
- Holding on to important documents

Provider Strategies:
- National Hotline as translation resource in over a hundred languages: 1-800-799-SAFE (7233)
What Is Sexual Coercion?

Creating a feeling, situation or atmosphere where emotional and physical control lead to sexual abuse or rape, or a victim feeling that he or she has no choice but to submit to sexual activity with the perpetrator.
Reproductive Coercion involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.
Birth Control Sabotage

**Tactics Include:**

- Destroying or disposing contraceptives
- Impeding condom use (e.g., threatening to leave her, poking holes in condoms)
- Not allowing her to obtain or preventing her from using birth control
- Threatening physical harm if she uses contraceptives
Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid.
Women, including teens, experiencing physical and emotional abuse are more likely to report **not using their preferred method of contraception** in the past 12 months (OR=1.9).

(Williams et al, 2008)
Pregnancy Pressure and Coercion

**Tactics Include:**

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that may cause a miscarriage
He really wanted the baby—he wouldn’t let me have—he always said, “If I find out you have an abortion,” you know what I mean, “I’m gonna kill you,” and so I really was forced into having my son. I didn’t want to; I was 18. […] I was real scared; I didn’t wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn’t want to have a baby but I was really scared. I was scared of him.

(Moore et al, 2010)
One-quarter (26.4%) of adolescent females reported that their abusive male partners were: (Miller et al, 2007)
Reproductive Coercion Within a Marriage

The odds of experiencing interference with attempts to avoid pregnancy was 2.4 times higher among women disclosing a history of physical violence by their husbands compared to non-abused women.

(Clark et al, 2008)
DSV Is a Leading Cause of Women's Health Issues
How does DSV impact physical health?
Injuries Among IPV/SA Victims

- **Injuries** resulting from the assault: including: bruises, broken bones, burns, spinal cord injuries, lacerations, knife wounds etc.

- **TBI:** 71% of women experiencing IPV have incurred traumatic brain injury (TBI) due to a physical assault

Abbott et al, 1995; Coker et al, 2002; Frye et al, 2001; Goldberg et al, 1984;
Golding et al, 1999; McLeer et al, 1989; Stark et al, 1979; Stark & Flitcraft, 1995)
IPV and Co-morbid Health Conditions

- Arthritis
- Asthma
- Headaches and migraines
- Back pain
- Chronic pain syndromes
- Genitourinary problems
- High cholesterol
- Heart disease
- Overweight/Obese
- Stroke
- Depressed immune function
- Irritable bowel syndrome

More than two-thirds of IPV victims are strangled at least once.

{ the average is 5.3 times per victim }

IPV is a leading cause of homicide.

Psychological abuse by an intimate partner was a stronger predictor than physical abuse for the following health outcomes for female and male victims:

- Depressive symptoms
- Substance abuse
- Developing a chronic mental illness

(Coker et al, 2002)
IPV and Behavioral Health Co-morbidities

- Anxiety/Panic Attacks
- Sleep problems
- Memory loss
- Post-traumatic stress disorder (PTSD)
- Depression, poor self-esteem
- Insomnia
- Suicide ideation/actions
- Alcohol, drug, tobacco use

What percentage of your clients’ pregnancies have been unplanned?
Reproductive and sexual health

• Women who disclosed abuse were at an increased risk for rapid repeat and unintended pregnancy

• Increased incidence of low birth weight babies, preterm birth and miscarriages

• Women disclosing physical abuse were 3 times more likely to have an STI

Women who are sexually assaulted by their intimate partner are more likely to experience:

- Chronic headaches and backaches
- Chronic stress-related problems such as irritable bowel syndrome and hypertension
- Depression, poor self-esteem
- PTSD
- Pelvic pain
- Pelvic inflammatory disease
- Bladder infections
- Sexual dysfunction
- Vaginal and anal complaints
- Unintended pregnancies, STIs

Campbell et al, 2002; Bennice JA et al, 2003; Bergman & Brismar, 1991; Bonomi et al, 2007; Campbell & Lewandowski, 1997; Campbell & Alford, 1989; Chapman JD, 1989; Dienemann et al, 2000; Domino & Haber, 1987; Plichta, 1996
DV increases women’s risk for UNINTENDED PREGNANCIES

(Sarkar, 2008; Goodwin et al, 2000; Hathaway et al, 2000)
Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls.

(Roberts et al, 2005)
Stop and Consider

What are other ways a partner can interfere with a female client’s birth control?
Can Men Experience Reproductive Coercion?

Yes, and there are gendered differences about the impact of this on men’s and women's lives.

• A female partner could lie about contraceptive use and he could become a father as a result.

**Question to consider: Were there threats or harm?**

• To date there have been no studies indicating men have become fathers when they didn’t want to be because she threatened to kill him if he didn’t get her pregnant.
Abused women are more likely to have used emergency contraception when compared to non-abused women.

(Gee et al, 2009)
Stop and Consider...

Can you think of a time when a patient's presenting health symptoms made you suspect there was a problem at home, but neither you nor your patient said anything?
Did You Know...

Many providers miss the underlying problem when they don’t consider IPV.

• Patients do not receive the care they need for the problem they have

• Treatment is often ineffective and the patient's health is further compromised due to a partial diagnosis
What We’ve Learned from Research

Studies show:

• Patients support assessments when done so privately
• No harm in assessing for DV
• Interventions improve health and safety
• Missed opportunities: patients fall through the cracks when we don’t ask
Women who talked to their health care provider about abuse were:

4 times more likely to use an intervention

2.6 times more likely to exit the abusive relationship

(McCloskey et al, 2006)
CUES: Universal Education and Safety Planning for DSV
Show of Hands

• How many of you have or know someone who has ever left something out of a medical history or intentionally misreported information to their healthcare provider?

• Why? What were they worried about?

• Did the way this question was worded matter?
• “No one is hurting you at home, right?” (Partner seated next to client as this is asked)—How do you think that felt to the patient?

• “Within the last year has he ever hurt you or hit you?” (Nurse with back to you at her computer screen)—Tell me about that interaction...

• “I’m really sorry I have to ask you these questions, it’s a requirement of our clinic.” (Screening tool in hand)—What was the staff communicating to the patient?
What if we challenge the limits of disclosure driven practice?
Universal Education provides an opportunity for clients to make the connection between violence, health problems, and risk behaviors.
Not Just Adding a Question on a Form

Multiple approaches to assessment:

- Validated assessment tools
- Adding questions to intake form (electronic or written)
- Universal Education:
  - Setting specific
  - Integrated
  - Brochure based
Group Activity

Take a couple of minutes and read the card carefully.

• How does using the safety card support both staff and clients?

• Pay attention to what stands out for you
Quick Activity

• Turn to the person next to you or behind you and give them your card and, in turn, they should give you theirs.

• What happens when you give the card to someone?
CUES Universal Education approach

C: Confidentiality: Disclose limits of confidentiality & see patient alone

UE: Universal Education + Empowerment:

Normalize activity:
"I've started giving two of these cards to all of my patients—in case it's ever an issue for you because relationships can change and also for you have the info so you can help a friend or family member if its an issue for them."

Make the connection: Open the card and do a quick review:
"It talks about healthy and safe relationships, ones that aren’t and how they can affect your health."

S: Support: “On the back of the card there is a safety plan and 24/7 hotlines that have folks who really understand complicated relationships”

• Warm referral
• Follow up at next appointment.
C: Before any discussion of D/SV in the health setting providers must:

- See patient alone (THIS IS A BIG DEAL) many clinics need to make adjustments because they haven’t done this routinely before
- Good signage matters
- Understand their reporting requirements
- Disclose the limits of confidentiality
Identify You Health & IPV Reporting Requirements

“Before I get started, I want you to know that everything here is confidential, meaning I won’t talk to anyone else about what is happening unless you tell me that you are being hurt physically or sexually by someone or planning to hurt yourself.”
“Before I get started, I want you to know that everything here is confidential, meaning I won’t talk to anyone else about what is happening unless you tell me that you planning to hurt yourself or someone else.”
Universal Education Sample Script:

• “We’ve started giving two cards to all our clients for two reasons—in case it might ever be useful for you and so you know how to help a friend or family member if it’s an issue for them.”

• “It’s kind of like a magazine quiz—it talks about safe and healthy relationships and what to do for ones that aren’t.

• “It makes connections between how relationships can really affect your health and well being.”

• “It has hotlines on the back and gives simple steps to take to be safer.” (Go over panels generally)
Universal Education: Practical Application

• Consider doing this after the webinar or at next staff training!!
• Divide into groups of three.
• One person is the provider, one person is the client, one person is the observer.
• Practice introducing the card.
• Your goal is to introduce the card using the script we have provided as your guide.
(The safety card) made me feel empowered because... you can really help somebody... somebody that might have been afraid to say anything or didn’t know how to approach the topic, this is a door for them to open so they can feel... more relaxed about talking about it.”
“They would bring out a card, basically walk in with it and she would open it and ask me had I ever seen it before. It was awesome. She would touch on, no matter what the situation you’re in, there’s some thing or some place that can help you. I don’t have to be alone in it. That was really huge for me because I was alone most of the time for the worst part.”
“[Getting the card] makes me actually feel like I have a lot of power to help somebody...”
S: Support: Important reminder

Disclosure is not the goal AND Disclosures do happen!
S - Support: What should be done if domestic or sexual violence is disclosed or suspected?

Your initial response is important
S: Positive disclosure: One line scripts

• “I’m glad you told me about this. I’m so sorry this is happening. No one deserves this.”
• “You’re not alone.”
• “Help is available.”
• “I’m concerned for your safety.”

Your recognition and validation of the situation are invaluable
Supporting survivors: What not to say

- “You should call the police”
- “You are definitely in an abusive relationship”
- “That does not sound like rape to me…”
- “Your partner is crazy, you need to break up with them”
- “What did you do to set them off?”
- “So what happened after that, and what happened after that?”
Providing a “Warm” Referral

• When you can connect to a local program it makes all the difference.

• “If you would like, I can put you on the phone right now with [name of local advocate], and we can come up with a plan for you to protect your safety.”
Role of the Domestic Violence Advocate

• Provide risk assessment, safety planning, and support

• Assist mothers and children who have experienced IPV to think and act in a way to increase personal safety while assessing the risks based on the perpetrators behaviors

• Connect clients to additional services like:
  - Housing
  - Legal advocacy
  - Support groups/counseling
DEFINING SUCCESS

☑ Safe environment for disclosure
☑ Supportive messages
☑ Educate about the health effects of violence
☑ Offer strategies to promote safety
☑ Inform about community resources—make warm, supported referrals
☑ Create a system-wide response
Using the Reproductive Health Safety Card
How might this safety card enhance client care?

Did You Know Your Relationship Affects Your Health?
Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn’t what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

✔ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).

✔ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can’t feel them. The IUD can be removed at anytime when you want to become pregnant.

✔ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won’t know.
Key Consideration

- If her partner monitors her menstrual cycles, an IUD may be the safest method to offer her.
- Especially if we cut the strings in the cervical canal so they can’t be pulled out or felt by a partner.
- The inconvenience of IUD removal with ultrasound may well be worth avoiding an unwanted pregnancy by an abusive partner.
Practice Bulletin No. 121

• It is important to note that some providers and health care systems have older protocols on IUDs and patient eligibility.

• In fact, ACOG states that LARC methods have few contraindications, and almost all women, including teens, are eligible for implants and IUDs.
Make sure pregnancy is the woman’s decision

Who controls PREGNANCY decisions?

*Ask yourself. Has my partner ever:*

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn’t agree to get pregnant?

*If I’ve ever been pregnant:*

- ✓ Has my partner told me he would hurt me if I didn’t do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered YES to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.
Harm Reduction Counseling

Specific to sexual and reproductive health:

• Birth control that your partner doesn’t have to know about (e.g. IUD, Implant)
• Emergency contraception
• Regular STI testing
• STI partner notification in clinic vs. at home
How does an intervention for reproductive coercion differ from an intervention for DV?
The Answer:

• When it comes to reproductive coercion, the health care provider is now key to intervention.

• This is done by offering harm reduction strategies for reproductive coercion and providing discreet methods of contraception.
Among women who received the safety card intervention and experienced recent partner violence:

• 71% reduction in the odds of pregnancy pressure and coercion compared to control group

• 60% more likely to end an unhealthy abusive relationship compared to control

(Miller et al, 2011)
DEFINING SUCCESS

☑ Safe environment for disclosure
☑ Supportive messages
☑ Make the connection of how violence can impact reproductive health
☑ Share birth control options that can be more hidden (IUD, etc).
☑ Offer strategies to promote safety
☑ Inform about community resources—make warm, supported referrals
☑ Create a system-wide response
FUTURES universal education patient safety cards

- General Women’s Health
- Reproductive Women’s Health
  - Adolescent card
  - HIV and Getting Tested
  - Pediatric setting card
  - Home visitation
  - Perinatal
  - Pregnant and parenting teens
  - Mental health and wellness
  - LGTB and Transgender communities
  - Multi-lingual cards: Spanish, Chinese, Tagalog
  - Native American focused cards, and more!

FUTURES WITHOUT VIOLENCE®
“So there’ll be times where I’ll just read the card and remind myself not to go back. I’ll use it so I don’t step back. I’ll pick up on subtle stuff, cause they’ll trigger me. I remember what it was like. I remember feeling like this, I remember going through this. I’m not going to do it again. For me, it just helped me stay away from what I got out of. I carry it with me actually, I carry it in my wallet. It’s with me every day.”
Self Reflection: On a Scale of 1 to 5

1 being ‘not at all’ and 5 being ‘completely’

Now how comfortable are you assessing for domestic and sexual violence and responding to any disclosures?
Thank You

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