Intimate Partner Violence: Screening, Assessment & Intervention in In-Home Support Situations

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Best Start Resource Centre 2015 Annual Conference-February 25, 2015

Objectives

- Define intimate partner violence (IPV)
- Describe prevalence & health effects of IPV
- Review importance of & strategies for asking about IPV
- Discuss principles for responding to a IPV disclosure
- Identify interventions for supporting women exposed to abuse
- Identify supervision & education needs
- Create a 'toolkit' for practitioners to address the issue of IPV

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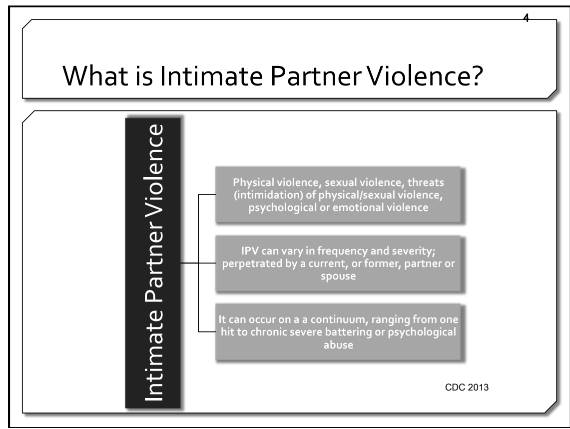
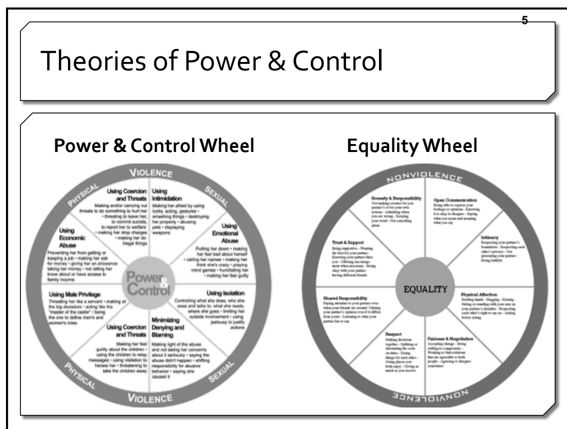
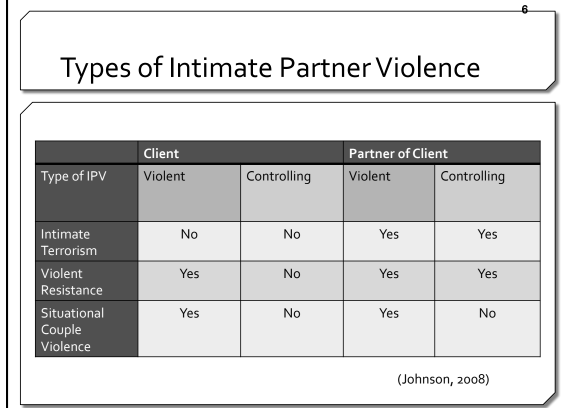
Before we start…

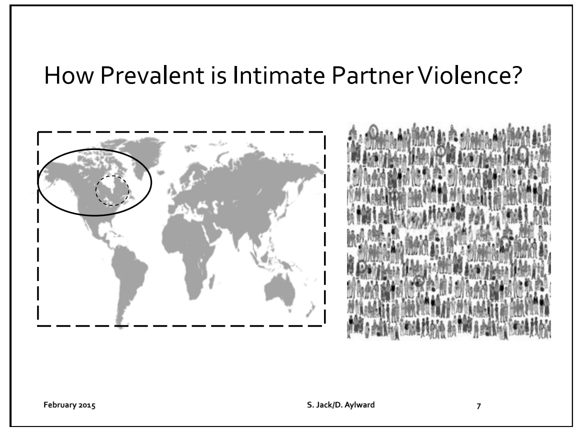


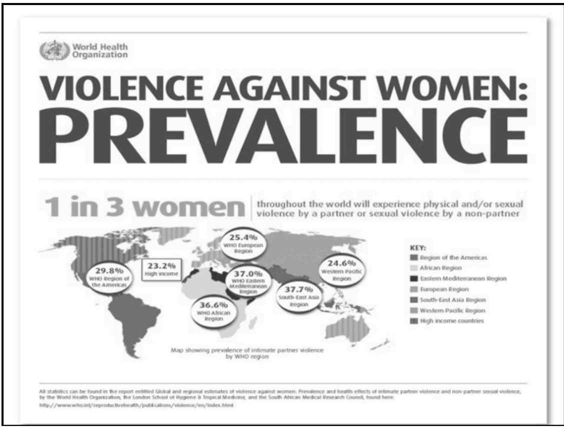




	Client		Partner of Client	
Type of IPV	Violent	Controlling	Violent	Controlling
Intimate Terrorism	No	No	Yes	Yes
Violent Resistance	Yes	No	Yes	Yes
Situational Couple Violence	Yes	No	Yes	No

(Johnson, 2008)





Canadian Violence against Women Survey

12,300 Canadian women >18 years of age

+ **51%** of women over the age of sixteen reported at least one incident of physical or sexual assault (in their life)
+ **29%** reported having been physically or sexually abused by their partner at some point in the relationship
+ **56%** of abused women were aged 18-34

(VAWS, 1993)

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General Social Survey on Victimization (2004, 2009)
- 6-7% of women (married/CL) experienced some sort IPV in previous 5 years
- ~24% in **Aboriginal** women

Family Violence in Canada: A Statistical Profile (2009, 2013)
- 83% of 'victims' of spousal violence were women
- Women are 4x more likely than men to be victims of **spousal homicide**
- ~**97,500** 'victims'in 2011; 80% women
- Violence among **dating partners** more prevalent than spousal violence
- Violence more common in **younger** Canadians (late 20s/early 30s/ 15-25 yrs)

Every **6 days** a woman is killed by an intimate partner (Stats Can, 2011)

Intimate partner violence accounts for **~1/5** homicides (Stats Can, 2006)

In 2005, **4 pregnant women** were killed by an intimate partner (Dauvergne & Li, 2006)

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Abuse during Pregnancy

- **21%** of women were abused ***during*** pregnancy (VAWS, 1993)
- ~**40%** of cases, abuse began during pregnancy (VAWS, 1993)
- **95%** of women who were abused in the first trimester were also abused in the 3-month period after delivery (Stewart, 1994)

Maternity Experiences Survey [MES] (2009)
- ~6% of women who had recently given birth had experienced IPV

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What the women said…

77% reported being pushed, grabbed or shoved

47% had something thrown at them

32% said they were abused **during** their pregnancy

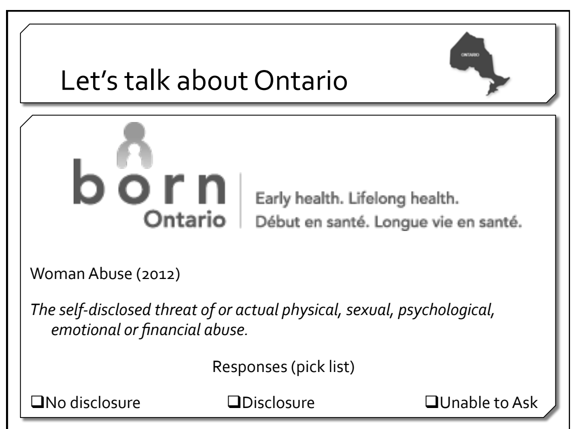
28% said abuse started **after** pregnancy

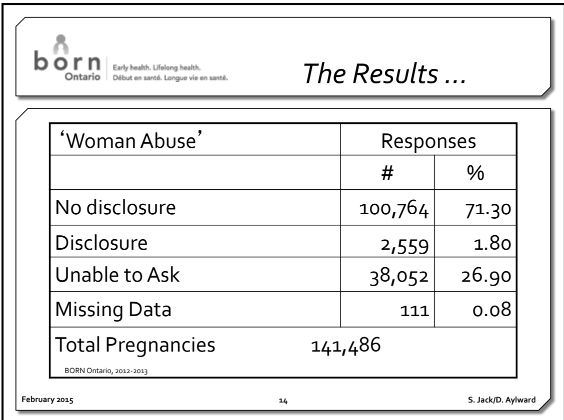
14% were choked

10% were beaten

8% were threatened with a gun or knife

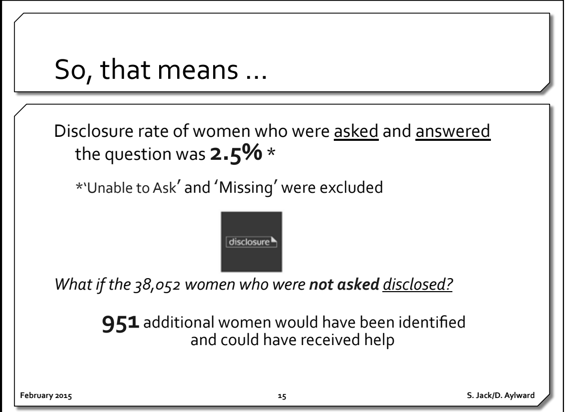
(MES, 2009)





'Woman Abuse'	Responses	
	#	%
No disclosure	100,764	71.30
Disclosure	2,559	1.80
Unable to Ask	38,052	26.90
Missing Data	111	0.08
Total Pregnancies	141,486	

BORN Ontario, 2012-2013



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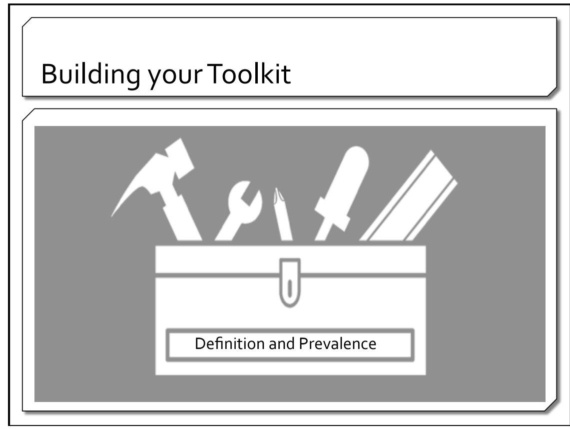

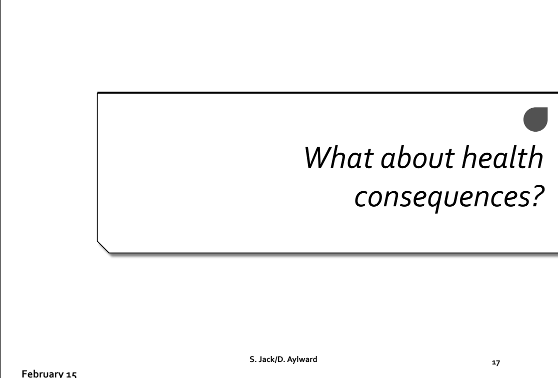

Health Consequences of IPV Exposure

General	Reproductive	Fetal & Newborn
Physical trauma/ injuries Stress/anxiety disorders Somatic disorders Substance abuse Chronic pain Eating/sleeping disorders Chronic medical conditions Depression (suicidal ideation, PTSD)	STIs Unprotected intercourse Unwanted pregnancies Spontaneous abortions Forced abortions Inadequate prenatal care Complications during labour and birth Infertility secondary to STIs	Placental abruption Poor fetal growth Preterm labour/birth Fetal injury Fetal death Neonatal infection 2° to STIs Neonatal death ↓ breastfeeding Bonding/ attachment issues

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Breastfeeding after Sexual Trauma

Kathleen Kendall-Tackett, Ph.D., IBCLC

For adult survivors of sexual abuse or assault, breastfeeding can be difficult. Unfortunately, sexual trauma is relatively common, affecting approximately 20 to 25 percent of women. Abuse survivors can experience a full range of responses to breastfeeding: from really disliking it to finding it tremendously healing.

Some people assume that survivors of sexual trauma do not want to breastfeed. But that is not what researchers have found. Two studies have found that abuse survivors were more likely to plan to breastfeed while pregnant, and start breastfeeding once their baby was born than non-abused women. And sexual trauma survivors breastfeed at almost exactly the same rates as women with no history of trauma.

If you are an abuse survivor who wants to breastfeed, I congratulate you for making a positive life choice to overcome your past and parent well. But I also want to acknowledge that you may face some unique challenges. I've included both sexual abuse and assault in this article because I have found that both can make a difference.

Sexual abuse is something that can happen within your family and can include everything from fondling to rape. Sexual assault often occurs outside the family and can also include attacks by peers. I have found that women have similar reactions to both of these experiences. Even if the sexual abuse did not happen in your family, your family may have been impaired in other ways, such as parental depression, partner violence or alcoholism, which increased your vulnerability to sexual assault.

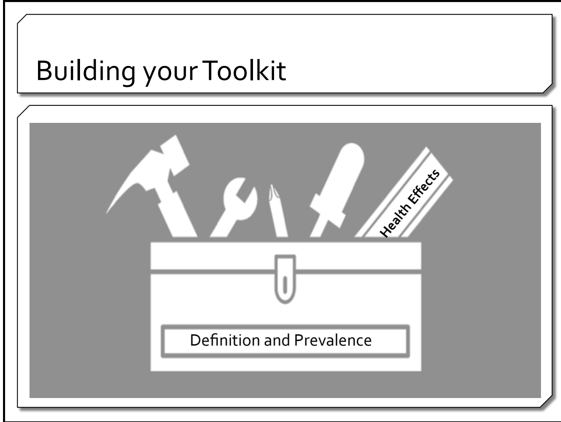
If you are having a hard time with breastfeeding, I have some specific suggestions that mothers have shared with me over the years. But mostly I suggest that you give yourself permission to do whatever works for and helps you. If you are having difficulties, your first step is to try to figure out what makes you uncomfortable. Is it nighttime feeding? Is it your baby touching other parts of your body while nursing? Is it latching on? Is it the intense skin-to-skin contact? Is it all of the above? The intense physical contact of breastfeeding may be very uncomfortable for trauma survivors in general. You might find breastfeeding painful because your abuse experiences lowered your pain threshold. The act of breastfeeding may also trigger flashbacks. There is a whole range of possible things that might be uncomfortable for you. If you're not sure, try keeping a diary for a week or so to see if you can identify some specific triggers.

Once you identify the trigger, the next step is to figure out if you can you address the problem. For example, if skin-to-skin contact is bothering you, can you put a towel or cloth between you and the baby? Can you avoid the feedings that make you uncomfortable? Nighttime feedings are often a good candidate. Would you be more comfortable if you pumped and fed your baby with a bottle? Can you hold baby's other hand while breastfeeding to keep her from touching your body? Can you distract yourself while breastfeeding with TV or a book. (Many mothers have told me that this works well for them.) Experiment and find out what helps.

Also remember that some breastfeeding is better than none. You may not be able to fully breastfeed, but every little bit helps. Even if you must pump milk and use a bottle, even if you are only breastfeeding once a day. Some abuse survivors find that they never love breastfeeding, but they learn to tolerate it. And that at least helps them meet their goals. Being able to tolerate might also be a more realistic goal for you.

In summary, past abuse does not have to be the blueprint for the rest of your life. I have known many abuse survivors who have gone on to become wonderful mothers. I am confident that you can, too.

Kathleen Kendall-Tackett, Ph.D., IBCLC is a health psychologist, board-certified lactation consultant, and La Leche League Leader. She is clinical associate professor of pediatrics at Texas Tech University School of Medicine in Amarillo, Texas. For more information, visit her Web sites: UppityScienceChick.com and BreastfeedingMadeSimple.com.



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Whiteman, Chamberlain & Greenway (2004) asked women who had been abused about the most useful thing that their healthcare provider did to help them deal with the abuse.

The overwhelming response was ….

'JUST BEING ASKED.'

Did you know…

pregnant women have a higher risk of experiencing violence during pregnancy than they do of experiencing problems such as pre-eclampsia, placenta previa or gestational diabetes … health concerns for which they are routinely screened?

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Your role in asking about abuse…

1. Awareness
   - ✓ Of signs of abuse
   - ✓ Of significance of asking
2. Identification
   - ✓ Through screening
3. Assessment
4. Safety Planning

MISSION: IMPOSSIBLE

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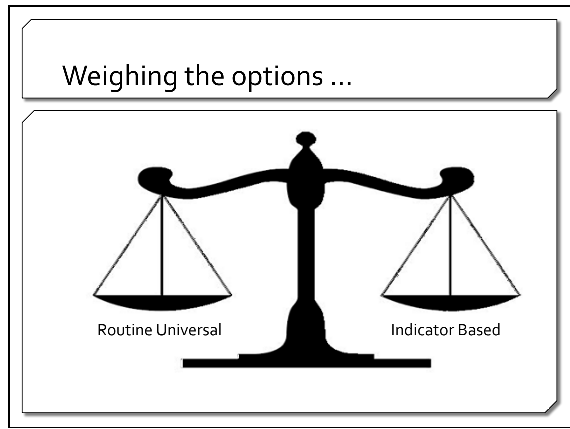

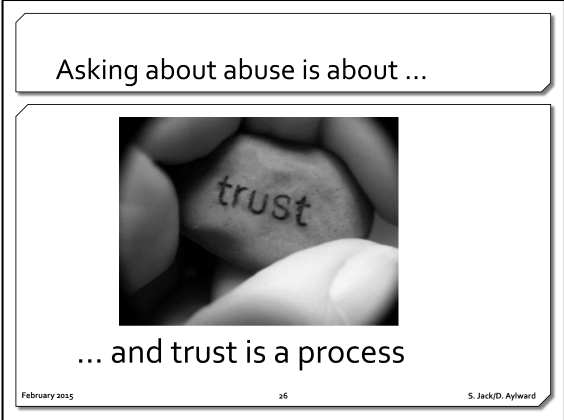

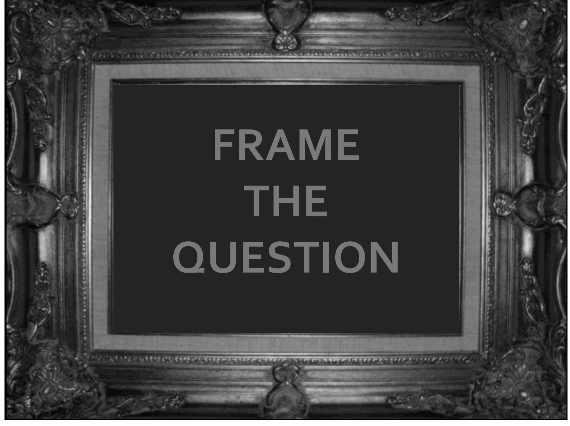

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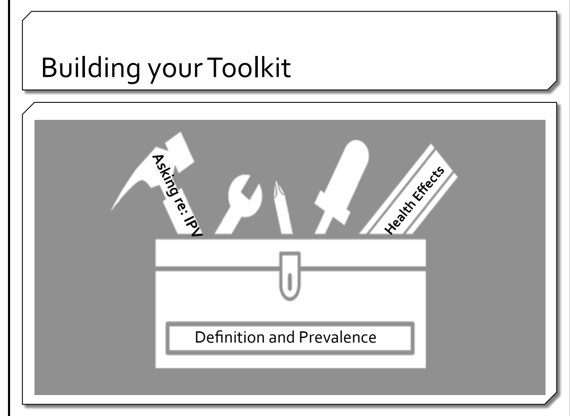
Your Task …

Find a partner [or group] and

1. Share your strategy for discussing IPV with your clients
2. Create a 'script' that may be used when you or your colleagues talk to women about IPV
3. Identify current guidelines or protocols that your agency uses and/or what other supports would be helpful
4. Discuss what additional information about IPV would be valuable to you in your current role

Building your Toolkit



Responding to Disclosures of Intimate Partner Violence

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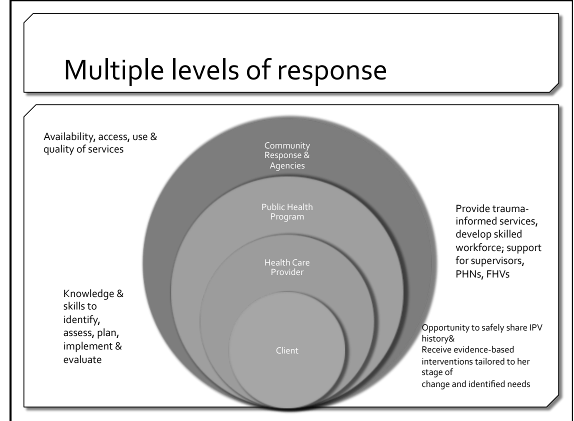
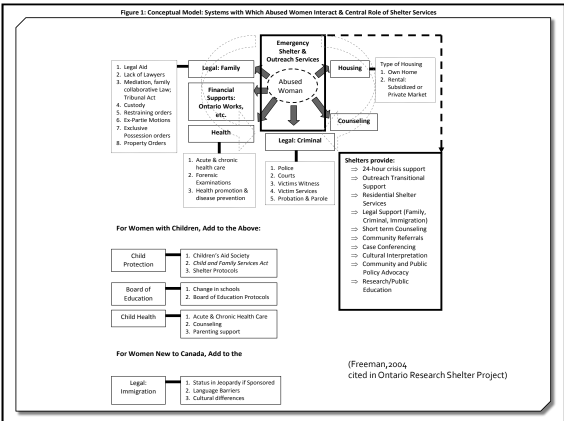
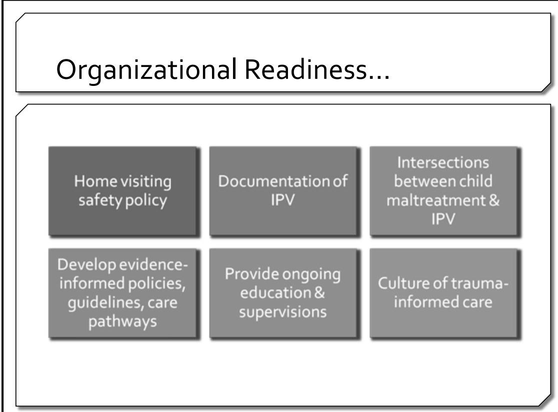


Community & System Level Response



Agency-Public Health Unit Level of Response



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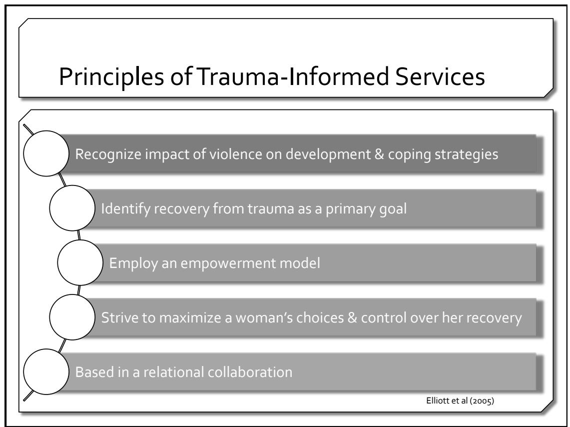

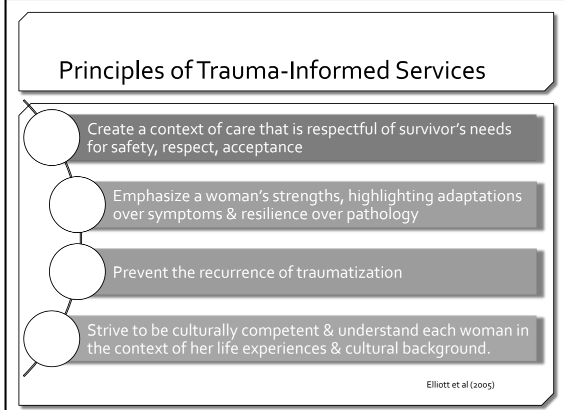

Provider-Client Relationship: Responding to IPV Disclosures

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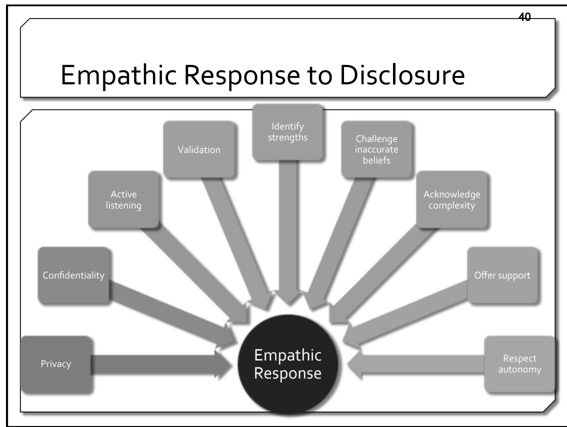
Empathic Response to Disclosure



Do not…

1. Ignore the disclosure
2. Blame or shame the woman
3. Screen women in the presence of others
4. Use family members to interpret
5. Sacrifice safety and confidentiality in the name of family-centred care
6. Assume that you know what is best or what will keep the woman safe
7. Take control or attempt to rescue
8. Judge the woman's choices

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Trauma Responses

- Triggers: sights, sounds, touch, smells, tastes –linked to abuse, memories of trauma
- Why might a health care setting or encounter act as a trigger?
- Symptoms of a trigger response:
  - Anxiety
  - Mild to moderate distress
  - Increased heart rate/respirations
  - Sudden display of fear or anger
  - Restlessness
  - Sweating
  - Startle response
  - Dissociation (rare)

Trauma Informed Care- Universal Precautions

- Ensure privacy
- Explain all procedures; seek consent
- Ask woman about her level of comfort (discomfort) and what might increase her comfort
- Provide options and choices to enhance comfort
- Avoid common triggers (those that nurse can control)-eg ask permission to touch
- Be mindful of woman's responses
- Support woman to deal with trauma response in a way that helps her regain sense of control, minimizes embarrassment, regain composure

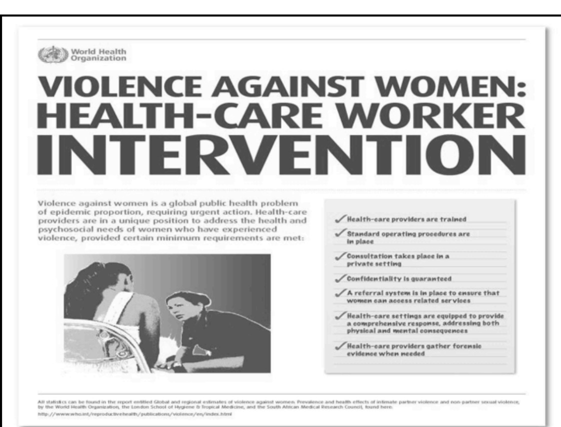
Your task …

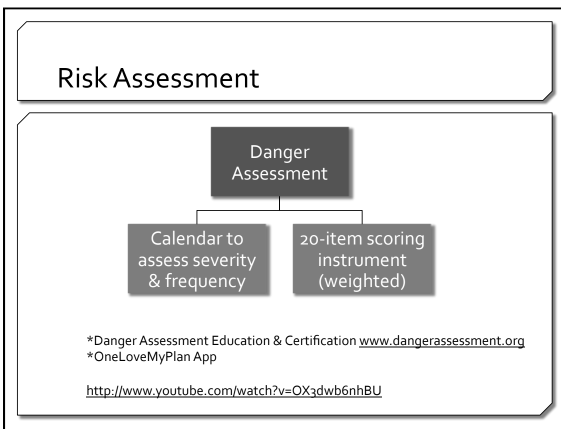
- Continue with your group or partner
- At the organizational level:
  - What supports currently exist to support managers, supervisors, public health nurses and family visitors respond to disclosures of IPV
  - What additional supports, policies or education is required?
- At the individual level, for you as a manager, supervisor, PHN or family home visitor:
  - What is your personal level of skill & confidence in responding empathically to a disclosure?
  - What additional education or support do you require to improve your knowledge/skill in responding to disclosures?

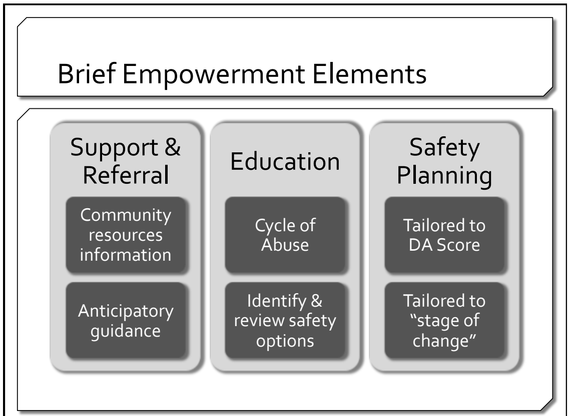
Building your Toolkit

Asking re: IPV
Responding to IPV
Health Effects
Definition and Prevalence

Now what? Planning &
Implementation of Care…


World Health Organization
VIOLENCE AGAINST WOMEN:
HEALTH-CARE WORKER
INTERVENTION
Violence against women is a global public health problem of epidemic proportion, requiring urgent action. Health-care providers are in a unique position to address the health and psychosocial needs of women who have experienced violence, provided certain minimum requirements are met:
Health-care providers are trained
Standard operating procedures are in place
Consultation takes place in a private setting
Confidentiality is guaranteed
A referral system is in place to ensure that women can access related services
Health-care settings are equipped to provide a comprehensive response, addressing both physical and mental consequences
Health-care providers gather forensic evidence when needed


Risk Assessment
Danger Assessment
Calendar to assess severity & frequency
20-item scoring instrument (weighted)
*Danger Assessment Education & Certification www.dangerassessment.org
*OneLoveMyPlan App
http://www.youtube.com/watch?v=OX3dwb6nhBU



Process of Resolving or Leaving Abusive Relationships

A complex trajectory....

Stages of Readiness to Change...

1. Not ready to make a change: Committed to the relationship
2. Thinking about making a change: Committed but questioning
3. Getting ready to make a change: Considering change & options
4. Making the change: Breaking free or curtailing abuse
5. Keeping it up: Establishing a new life together or apart

Dienemann & Campbell (2002)

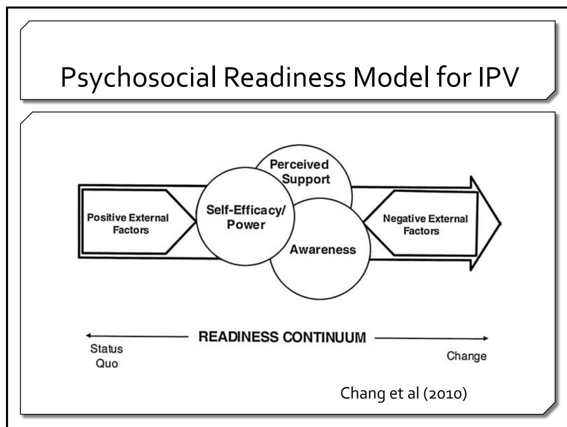
Domestic Violence Survivor Assessment Form

Issues about the relationship................

Causes of abusive incidents?	Denies & excuses abuse. May accept blame by partner.	Questions self blame Vague talk rela. ending. Looks for logic in causes of incidents.	Rejects self blame. Continues to make excuses to others, but realizes he chooses to abuse.	Partner is accountable abuse. Assesses safety – partner change or time to leave	Intends violence past. If left, avoids partner. If together Monitors partner for change.
Managing Partner Abuse	Sees partner control as trade off for good in relationship	Placates, feeling trapped. Asks partner to get help	Realizes cannot prevent partner abuse. Tries to avoid abuse by sleep, work, etc.	Abuse must end. Makes and acts on plans for own safety.	Learns new ways to relate to new/changed partners. If left, makes excuses to avoid abuser.
Love & Isolation	Tries to love enough. Keeps abuse secret.	Loves & "Gives 2nd Chance" Shame is secret. Tries to not think about abuse.	Ambivalent losing home, partner, dreams. Begins to identify with survivors.	Embarrassed. Yearns for what may have been. Plans and acts to avoid danger.	If left, reminds self why; feels void, nostalgia for love & loss. If apart or together builds support network.
Views Relationship and Options	Positive overall. No need for options. Violence temporary.	Reflects on good and bad, overall OK. Try change self, dreads abuse	Ambivalent. Tries options to help partner change &/or tries leaving for 1-2 nights. .	Determined abuse must end. Willing "to do what it takes" over time to become safe	If she leaves, partner may plead, stalk, harass. Regardless, has learned to weigh options.
How my friends/ family see relationship	Fears stigma of failure in relationship.	Remains "for the family, or status, or children" Does not want partner humiliated.	Struggles own loyalty and rising sense injustice. Thinks what is too much?	Partner does not deserve loyalty. For many there is a precipitating crisis.	Feels justified in leaving or monitoring partner's change with some lingering guilt.

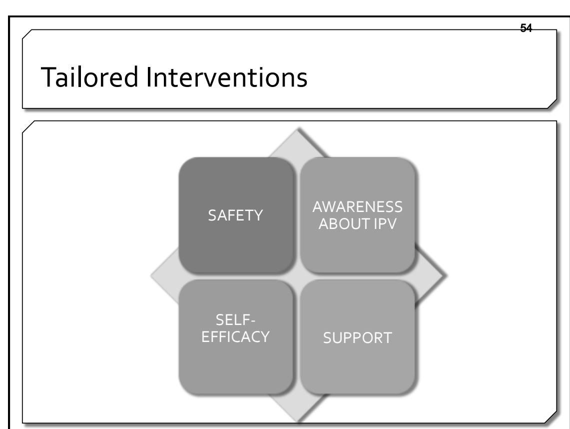
Dienemann & Campbell (2002)

Psychosocial Readiness Model for IPV



Chang et al (2010)

Tailored Interventions

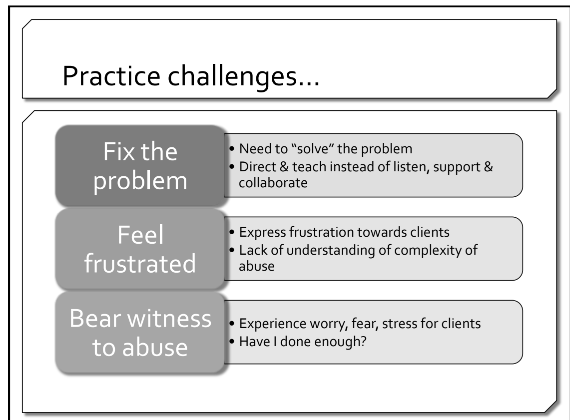


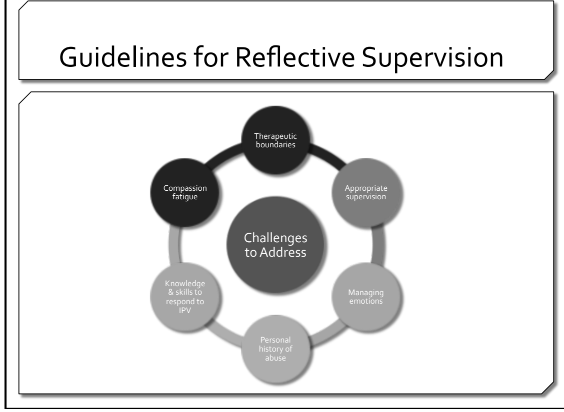
Your task…

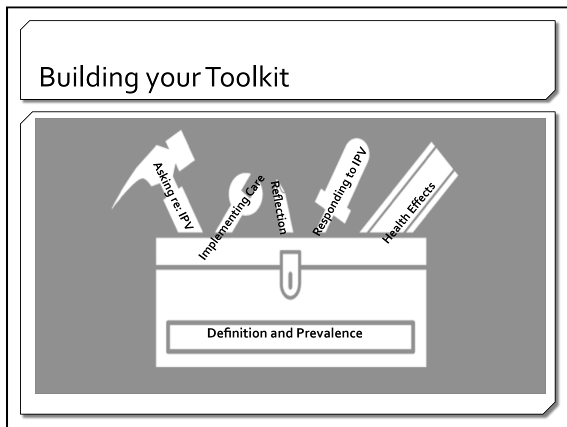
- As a group we will discuss…
  - How service providers are intervening (planning and implementation of care) with women exposed to abuse in a variety of care situations (telephone, home visits, community contexts).
  - Discuss what is an appropriate level of intervention for the work you do?
  - What are the additional tools that individuals or organizations require to better respond to IPV?

Building your Toolkit

Impact of working with women exposed to abuse on health care providers…


Practice challenges…
Fix the problem
• Need to "solve" the problem
• Direct & teach instead of listen, support & collaborate
Feel frustrated
• Express frustration towards clients
• Lack of understanding of complexity of abuse
Bear witness to abuse
• Experience worry, fear, stress for clients
• Have I done enough?


Guidelines for Reflective Supervision
Challenges to Address
Therapeutic boundaries
Appropriate supervision
Managing emotions
Personal history of abuse
Knowledge & skills to respond to IPV
Compassion fatigue


Building your Toolkit
Asking re: IPV
Implementing Care
Reflection
Responding to IPV
Health Effects
Definition and Prevalence

Professional Development

Knowledge...

- Defining intimate partner violence
- Prevalence
- Health effects of exposure to IPV on:
  - Women's mental and physical health outcomes
  - Pregnancy outcomes
  - Infant/child health and development
- Mental health effects of IPV exposure
- Trajectories of abusive relationships

How to Assess/Identify IPV

Skills

- How to ask the questions
- How to conduct a clinical IPV assessment
- How to identify & explore risk indicators
- Risk assessment (Danger Assessment) http://www.dangerassessment.org

Resources

Responding to Domestic Violence in Clinical Settings

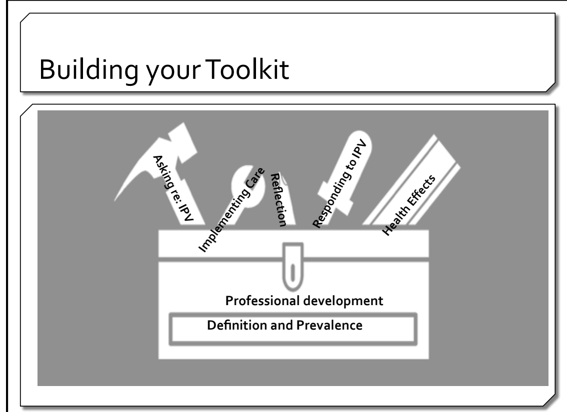
Intervention du Service des Urgences en cas de Violence Familiale

English Français

http://www.dveducation.ca

Our task…

- How do we prepare managers, public health nurses and family home visitors to:
  - Understand IPV
  - Identify and assess for IPV
  - Respond to IPV disclosures
  - Provide support to families exposed to violence
  - Intervene with families exposed to violence
  - Provide and receive supervision related to working with families exposed to violence and other traumas
  - Prevent compassion fatigue



"There is one universal truth, applicable to all countries, cultures and communities: violence against women is
never acceptable,
never excusable,
never tolerable."

Ban Ki-Moon, UN Secretary-General, 2008

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Questions??

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Ontario Shelter Research Project
http://www.ontarioshelterresearchproject.com/overview.html

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