Chapter 260 Narrative

Slide 1: Title Slide

Slide 2: Trigger Warning

This training covers topics that may potentially cause stress or anxiety. Please take care of yourself throughout your review of this material.

Slide 3: The purpose of this training is to fulfill Chapter 260 an act relative to Domestic violence-making training and education in sexual and domestic violence mandatory for

Chapter 260 AN ACT RELATIVE TO DOMESTIC VIOLENCE

Section 9 Chapter 112 of the General Laws is hereby amended by adding the following section:-

Section 264 - The board of registration in medicine, the board of registration in nursing, the board of registration of physician assistants, the board of nursing home administrators, the board of registration of social workers, the board of registration of psychologists and the board of registration of allied mental health and human services professions shall develop and administer standards for licensure, registration or certification pursuant to this chapter, as applicable, and any renewal thereof, that require training and education on the issue of domestic violence and sexual violence, including, but not limited to, the common physiological and psychological symptoms of domestic violence and sexual violence, the physiological and psychological effects of domestic violence and sexual violence on victims, including children who witness such abuse, the challenges of domestic violence and sexual violence victims who are gay, lesbian, bisexual, transgender, low-income, minority, immigrant or non-English speaking , availability of rape and sexual assault shelter and support services within the commonwealth.

Slide 4: Learning Objectives:

1. Define and describe prevalence of sexual and Domestic violence and explain and identify the dynamics of sexual and intimate partner violence

2. Identify the impact of sexual and intimate partner violence on individual's immediate and long-term physical and emotional health

3. Describe and provide universal education regarding sexual and/or domestic violence to all clients/patients

4. Respond appropriately to a disclosure of sexual and/or domestic violence as well as to the absence of disclosure when a patient/client is presenting signs suggesting that they may be experiencing violence

5. Explain and understand the importance of creating collaborative relationships with sexual and domestic violence service providers

6. Identify available local resources and make appropriate and supportive referrals

Slide 5: Racial Equity and Health Disparities

Race or ethnicity, gender identity, sexual orientation, age, disability, socio-economic status, geographic location, all are factors in one's ability to achieve and have access to maintain good health.

To move toward Health Equity

1. People should be valued equally
2. Focus should be on addressing avoidable inequities, health and healthcare differences and historical and contemporary injustices

3. Keep in mind the absence of disease is not always the equivalent of good health

Health equity is defined as attainment of the highest level of health for all people. It goes on to define health disparities as adversely affecting populations who have systematically experienced greater obstacles to health based on their religion, socio economic status, gender identity, racial or ethnic group, age, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to intentional and unintentional discrimination, exclusion, or marginalization. In order to reach health equity, health disparities have to be addressed

This is the lens through which we would like for you to view all prevalence data

Section I: Do No Harm

Before attempting to make a go at universal education of patients or clients for Sexual and or Domestic Violence it is important that health and mental healthcare professionals do some self- inventory and be honest about barriers they face in the following areas…personal, interpersonal, and or organizational/resource.

Personal barriers: such as your own attitudes' and perceptions around DV, such as thinking it is a private issue, fear of offending patients, fear of the patient's abuser, lack of understanding of abuse, or lack of confidence in providing universal education. This includes having misconceptions around someone leaving an abusive situation. Not realizing that leaving oftentimes puts survivors at an even greater risk,
It is also important to note that there is no "typical" victim or "typical" perpetrator of sexual and or Domestic Violence. It is important to reconcile this with your personal beliefs.

Interpersonal barriers: any barriers that affect your ability to work with a patient or client. i.e. language, culture, and misunderstandings about the reasons the survivors chooses to stay with their abuser

Organizational Barriers: With time constraints, inadequate resources and support, Electronic Medical/Health Records makes it difficult to allow for the narrative of survivor voices to be recorded and or may not allow for a distinct map of the survivor's body so that injuries may be properly recorded.
Danger often increases when a survivor first leaves their abuser since abuse is about the abuser maintaining power and control. Domestic Violence is often counter-intuitive. When the survivor leaves the abuser often escalates their tactics in order to regain power and control of the survivor.

Keeping these barriers in mind, it is important to note that you already address hard topics with patients/clients, asking them very tough and personal questions, so what is the harm in getting to know your patients and clients by asking them about the relationships in their life and their experiences.

The facts:
Studies reveal that the majority of (43 to 85%) women want healthcare providers to ask them about abuse and reported that if asked directly, they would disclose. Most women, reported that it would be uncomfortable to be asked about DV but agreed that it is important to ask.

70 – 93% of survivors don't know where to get help or may not have the ability to safely seek help, so when health or mental healthcare professionals identify survivors, they have a unique opportunity to be a bridge between patients/clients and appropriate community-based services.

The Goal of intervention, however, is not disclosure it is also not to Triage or to solve the problem, but it is an opportunity for individual client or patient to define for themselves what safety looks like. The goal of intervention is to acknowledge that safety should be available to all, and that everyone has the right to safety

Safety for all as (Defined by the survivor) is paramount
Next is Survivor autonomy and empowerment and it involves placing the power and control back in the hands of survivors, acknowledging and utilizing personal resources and strengths
Change social/cultural norms: breaking the stigma around domestic violence, intimate partner violence and sexual assault

Section I: Do No Harm -Trauma-Informed Care

Trauma Informed Care:
To ensure we are all on the same page, when we are referring to Trauma, we are referring to….
A traumatic experience that can be a single event, a series of events, and/or a chronic condition (e.g. childhood neglect, Domestic violence, sexual assault). Individuals may experience the traumatic event directly as a witness to an event, feel threatened, or hear about an event that affects someone they know.

Trauma generally overwhelms an individual's or communities' resource to cope and it often ignites the fight or freeze reaction. It frequently produces a sense of fear, vulnerability and helplessness

What is Trauma?
Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being

Trauma Informed Care (TIC) is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his, her or their response to behavioral health and mental health services from prevention through treatment.

Trauma-Informed Approach incorporates three key elements…
The 3 R's
Realizing the prevalence of trauma
Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and
Responding by putting this knowledge into practice…

Culture as it relates to Trauma –Informed Care
Whatever our cultural backgrounds are, cultural references and identity shape how we perceive, interpret, and express distress in response to traumatic events culture influences what type of threat is perceived as traumatic. Here are some best practice points to think about as a response to trauma

1) Consider somatic/behavioral presentations of distress
2) Share control (ask questions that are direct and allow the patient/client to do the talking),

3) If your patient or client is referring to their partner as husband you mirror their reference, or if they call their grandmother abuela, you should as well
4) Be open to involving other healing professionals and customs (pastor, elders, spiritual guides, etc.)
5) Try to connect families with community resources they trust, be sensitive to any fears the family may be facing (around immigration status, legal status, involvement with the criminal justice system, etc.) and show respect by working within (if safe to do so) and through the family structure
6) Culture forms a context through which traumatized individuals or communities view and judge their own responses

For example, if people think their community will not accept them as victims or survivors they may tend to withdraw and be silent, even worse they may internalize this view and adopt the adverse reactions as a fault of their own

Important things to remember…

There are families in which there are multiple generation living within one household. In households were there are multiple generations living within its important to look at all the household dynamics and to think of the household complexity, when and if there if a finding of abuse present.

Be mindful not to assume that the abuse is being perpetrated by an intimate partner

In providing Trauma Informed Care, it is important for providers to

- Recognize and validate patients/clients' disclosure of abuse or assault
- To provide patients/clients with information about available resources
- Partner with community agencies and or in-house SDV programs within the hospitals that are proficient in SDV
- Reduce sense of isolation and shame

Section I: Do No Harm: Coordinated Connections

Disclosures do happen
However….Disclosure is not the Goal…the goals are to provide trauma informed services
To Make a coordinated connection
Or a collaboration w/a local
Sexual and Domestic Violence (SDV) program
To Become well versed with local &
Statewide S and DV services to ensure appropriate referrals

The value of coordinated connections with Sexual and Domestic Violence programs- developing a relationship with your local SDV programs allows you to tap into…..

The valued Experts housed at each program
They can provide consultation & support your work
SDV programs can provide critical services to your clients and patients (including but not limited to 24-hour hotlines, shelter, support groups, counseling, legal advocacy and other assistance)
Assist survivors by providing a community safety net & specialized services

Benefits you bring to the table…
Assist program SDV staff assist survivors on how to access and navigate the health/mental health care system

Health, mental healthcare education & promotion

Networking and resource sharing and

How Collaboration on education & prevention efforts

How to build a coordinated connection

1) Make a phone call and familiarize yourself with the various services offered by programs gather contact names
2) Learn who is the best person to contact for specific services (if possible)
3) Visit local services or programs
4) Establish an MOU or MOA

Why Trauma Informed Universal Education?
Promotes education and normalizes conversations about violence with all clients
Promotes that disclosures are met with empathy, competence and with appropriate referrals
Provides a context that gives patients/clients a natural segue way in conversation to connect their own experience with the information provided to them

Trauma-informed care places an emphasis on appropriate referrals and a harm-reduction message around decreasing future risk of abuse. Trauma informed care acknowledges the possibility of undisclosed trauma in a person's life and calls upon providers to deliver their services without unintentionally re-traumatizing the individuals they serve.

Trauma Informed Universal Education provides an opportunity for primary, secondary and tertiary prevention

Primary Prevention: The goal of primary prevention is to protect healthy people from developing a disease or experiencing an injury in the first place. For example, using universal education as an open door to educate about healthy relationships and the early signs of an unhealthy relationship. This includes preventing initial victimization and perpetration

Secondary Prevention: The goal of secondary prevention is to treat those who have exhibited some risk factors of SDV victimization or perpetration the goal is to halt or slow down the continuum of violence which typically escalates over time and the implications it has on one's health. The involve immediate responses to SDV with short-term consequences

Tertiary Prevention: These approaches work to prevent the progression, over time and to eliminate or lessen the harm that has already been experienced as a result of SDV

There are multiple approaches to Universal Education

Building a Relationship with your patient or client is the best foundation for inquiry maximize building relationships by following up with your patients.
Know that it's more than just a adding a Question on a form, it's getting to know your patient's or clients their experiences and their relationships

There are validated assessment tools for Sexual and Domestic Violence however, beware of the limitations of even validated tools, many of these tools were created and evaluated decades ago, therefore many of the tools are not fully inclusive or culturally informed. Many of the tools are just for IPV and do not ask questions that could potentially reveal any other forms of Domestic Violence such as elder abuse

Combine verbal inquiry with written visible material/education helps to recreate a climate for inquiry and should be notice and can include Buttons, posters, tear-off cards or flyers, and newsletters. This assists with normalizing the conversation around sexual and domestic violence.

Section I: Do No Harm: MA Reporting Requirements

Before you get started it is important to consider the following regarding Confidentiality and Safety…

1) Always talk to patient/client's alone and not within earshot of a partner or family member (including children) & never use a family member or friends as an interpreter

2)Because universal education could trigger a disclosure of abuse or other situation that requires a report to law enforcement or child welfare, it is essential that the limits of confidentiality and mandatory reporting requirements are reviewed with all patients/clients prior to any anticipatory guidance about IP and Sexual violence
3. Forms should indicate the patient/client conditions that require reporting to health or law enforcement authorities and consent forms should indicate the limits of confidentiality

4. Understand your reporting requirements (based on local laws and the policies and procedures of your practice settings). They are as follows:

<u>MA Reporting Requirements</u>
Child Abuse & Neglect must be reported to the Department of Children & Families (DCF) if, when acting in your professional capacity, you have reasonable cause to believe that a child is suffering certain kinds of physical or emotional injury.

1. Abuse inflicted upon the child which causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse
2. Neglect, including malnutrition; or
3. Physical dependence upon an addictive drug at birth

Reports must be made orally to DCF followed up by a detailed written report within 48 hours.
Keep in mind….

- Every situation involving domestic violence isn't one to be report to DCF
- Filing when a caretaker is overwhelmed by a domestic violence situation can mistakenly penalize the caretaker

The fearful environment created by a perpetrator undermines the ability of the caretaker, and the caretaker's family and friends to help protect children

There may be other incidents in which reporting may be required For instance if the victim is a minor, an elder, or a person with disabilities

<u>Statewide Resources</u>
You are all mandated reporters…

Reporting Hotlines in Massachusetts

Minor children (under 18) abuse or neglect by a caretaker:
Department of Children and Families (DCF): local area office or the Judge Baker child-at-risk Hotline (24/7) 800-792-5200
Adults with Disabilities (ages 18 – 59) abuse by a caretaker:
Disabled Persons Protection Commission (DPPC) Hotline (24/7) 800-426-9009

Elders (age 60+) abuse, neglect, exploitation by a caretaker (or self-neglect of an elder age 60+ who is NOT in a long-term care facility):
Executive Office of Elder Affairs, Elder Abuse Hotline (24/7) 800-922-2275
Patients in health care settings abuse, neglect, mistreatment or misappropriation of property of a patient in nursing/rest home or by staff of a home health, hospice or homemaker agency:
DPH Division of Health Care Quality Complaint Unit 800-462-5540

The Provider Sexual Crime Report (PSCR) was created to help assess the volume and characteristics of rape and sexual assault occurring in MA without identifying the survivors. Massachusetts General Law requires Medical Providers to complete the PSCR anytime a patient is examined or treated for care related to sexual assault. For a copy of the PSCR please refer to the supplemental section.

Section I: Do No Harm: Warm Referrals

Things to remember:
Maximize your time with clients or patients by taking time out when visiting with a patient or client make eye contact with the patient/client. If you are administering a tool, it should be the only thing you are doing; you should minimize or eliminate other activity. Normalize Conversation about S and DV.

Get to know every one of your patients/clients. Learn about their family, their household dynamics, and their culture; ask questions about their relationships, "What do you like about your relationships in your life, (starting with the people in your household)?" "If you could change something/or one thing about your relationships what would it be?"
Rapport

Rapport: Again, disclosure is not always going to happen, nor is it the end goal. A patient/client is more likely to share with you once they feel as if they have built a rapport with you. You may ask the same set of questions and receive different answers depending on the level of Rapport and trust you have established with an individual

Remember to watch out for your own assumptions and bias and know that your initial reaction may affect the survivors' feeling of safety as well as an indicator for them as to whether or not you are safe person to talk too.

Whether or not a patient/client discloses it is important to thank the patient/client for sharing their response to the questions. If a patient/client does feel comfortable to share

their experience and gives you a positive disclosure, it is important to follow up with a validated statement.
“I am so sorry this happened to you” “I believe you, it’s not your fault”

What are Warm Referrals?

A warm referral is an introduction of sorts
It involves the referral source making a phone call (referral) by way of introduction on behalf of someone in need, connecting them to a service
This call is made in private
The call is made together (both referral source and survivor)
Warm referrals are optional (at the survivor’s discretion)

To assist you in recalling the information shared in this training, we have created the acronym CLEAN CARE

C is for confidentiality and connections: it is important prior to starting any screening or assessment for IPV or SV by establishing the limits of your confidentiality prior

L is for listen: it is important to listen to what your patients say and what they don’t say. Pay attention to adjectives used, body language, etc.

The first E is for empathy, if a patient shares with you, it is important to demonstrate your belief by using a validating empathic statement. Such as “I believe you and I am so sorry that this has happened to you”, “It is not your fault, no one deserves to be treated like that”, or “thank you so much for sharing with me, I know that must have been difficult”

The A is for autonomy: it is very important that survivors be given autonomy, resist being directive, telling them what they should do, or what you would do if you were them. The power is in the hands of the survivor, this is true for reporting as well; you are not mandated to report Sexual Violence or Intimate Partner Violence, the power to report solely at the discretion of the survivor. In addition, what course of action they want to take in regard to services or whether or leave or stay is also solely at the discretion of the survivor

The N is for normalizing the conversation: SDV is a common but serious public health problem. Normalizing the experience can assist the survivor, so that they know that they are not alone. You can display normalization by reminding your patient that “IPV happens more frequently than we know and in all types of relationships”.

The second C is for connections – prior to engaging in universal education, making a connection with your local Sexual and or Domestic Violence program/s.

The second A is for ask: When sharing information whether its resources and or an anecdote, ask permission of the patient. "Would it be alright, if I shared something with you?" or "I've worked with a client on this before, is it okay if I shared the same resources with you?

R is for Resources: Link patients/clients to and or share relevant resources to them, asking permission, first. "There is help available, and when and if you are ready, I would like to share some resources with you"? "I can call an advocate I know at local Rape Crisis Center, I have called them before and they have been extremely helpful, we can call together in my office". When offering resources provide supportive referrals whenever possible, making the effort to notify resources alongside of the clients, and or giving them safe space to do so within the confines of your office, is also helpful.

The second E is for empower: You can demonstrate empowerment for patients by placing the decision-making back in their court, by validating what they have charged and reminding them that they are capable of making the best decisions for themselves and their families "I believe you know what is best for you (and your children). I have information that can assist you know and later."

Please refer to the list of local and statewide Sexual and Domestic Violence Services in the supplemental section.

Section II: Sexual Violence

Sexual Violence Definition
Sexual violence is any non-consensual sexual contact or penetration, intentional touching, trafficking, and non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment whether (in person, via phone, email, or text) by one person toward another**.**
Sexual violence includes…

Rape defined as forced or non-consensual sexual penetration of any body part by an object and/or individual. A person is forced into sexual intercourse through threats, physical restraint, and/or violence

Sexual Assault: which includes unwanted behaviors that are attempted or completed against one's will or when one is unable to consent. This includes, but is not limited to, actual or threatened, physical force, use of weapons, coercion, intimidation, and sexually offensive touching.

Sexual Harassment/exploitation: includes, but is not limited to, sexual advances, requests for sexual favors, inappropriate sexual comments, exhibitionism, undesired exposure to pornography, sexually explicit stalking, incessant telephoning, taking nude photographs, of a sexual nature, of another person without their consent, online solicitation of minors, unwelcome online solicitation of adults, and any hostile environment where sexual joking is present without consent

Who is at Greatest Risk for Sexual Victimization

Adolescents aged 16 to 20, college students, people with disabilities, People who identify as LGBT, prison inmates, people experiencing homelessness, immigrants and non-English speakers, and people who have previously experienced sexual victimization.

Section II: Sexual Violence - National Prevalence

According to the National Intimate Partner and Sexual Violence Survey 1 in 5 women (18.3%) and 1 in 71 men (1.4%) report being raped in their lifetime.

Sexual Violence among High Risk Populations:

Approximately 1 in 8 lesbian women (13%) and nearly half of bisexual women (46%) have experienced rape compared to 17% of heterosexual women

4 in 10 gay men, and nearly half (47%) of bisexual men have experienced SV other than rape as compared to 21% of heterosexual men.

At Every Turn: A Report of the national Transgender Discrimination Survey found that ….
1 in 2 transgender people have experienced sexual abuse/assault in their lifetime:

- 13% of African-American transgender people report being sexually assaulted in the workplace;
- 22% percent of homeless transgender individuals report being assaulted while staying in shelters;
- 15% of transgender individuals report being sexually assaulted while in police custody or jail - this number doubles for African-American transgender individuals with 32% reporting sexual assault while in custody

People experiencing poverty

According to a study completed 2008-2012, people living in poverty (39.8 per 1K) experienced more than double the rate of violent victimization including rape/sexual

assault compared to people in high income households (16.9 per 1K). This overall pattern was true for both black and white people experiencing poverty as well as for people experiencing poverty within urban and rural communities. This study also revealed that rape and sexual assault almost doubles for people experiencing poverty and remains the highest within urban communities as compared to people at higher income levels living within suburban and rural communities.

Race & Ethnicity

Approximately 1 in 5 non-Hispanic black women, 1 in 5 white non-Hispanic women and 1 in 7 Hispanic women have experienced rape in their lifetime

More than ¼ of American Indian or Alaskan Native women and
1 in 3 multicultural women have also experienced rape in their lifetime
Just shy of ½ of black women, ½ white women, and ½ American Indian or Alaskan Native, ½ multicultural women, 1 in 3 Hispanic women, and 1 in 3 Asian or Pacific Islander report having experienced sexual victimization other than rape in their lifetime

Just shy of ½ of black women, ½ of white women, and ½ of American Indian or Alaskan native women, ½ of multicultural women, 1 in 3 Hispanic women, and 1 in 3 Asian or Pacific Islander women have experience sexual victimization other than rape in their lifetime

Between 1/5 and ¼ black non-Hispanic men and between 1/5 and ¼ white non-Hispanic men and between 1/5 and ¼ Hispanic men have experienced rape in their lifetime

1 in 6 Asian or Pacific Islander men and nearly 1/3 of American Indian or Alaskan Native men have experienced rape in their lifetime.

Immigrants &
Non-English Speakers

13.1% of US population is foreign born (over 41 million people), a little more than 50% are female and 50% do not speak English or doesn't speak it well. 5.1 million foreign-born women are undocumented

Immigrant women are among the most vulnerable workers in the United States, finding themselves routinely abused under and unpaid, forced to work long hours for low or below minimum wage with little to no benefits. Female Immigrant workers, especially farmworkers (21% of farmworkers are female) are subjected to sexual abuse by employers and or co-workers. This vulnerability to sexual assault and harassment is heightened for

farmworkers because of the geographic isolation. Many sexual assaults/injustices happen and remain unreported due to the victim's immigration status.

For prevalence information regarding additional high-risk populations please refer to the infographic handouts

Section II: Sexual Violence - Associated Consequences

Sexual violence can have harmful and lasting consequences for survivors, families, and communities. The following list describes some of the consequences associated with sexual violence.

Associated Health Consequences:
Unintended Pregnancy
Chronic pain
Gastrointestinal disorders
Gynecological complications
Migraines and other frequent headaches
Sexually Transmitted Infections
Cervical Cancer
Genital injuries

Social Consequences:
Strained relationships with family, friends,
& intimate partners
Less emotional support from friends & family
Less frequent contact w/friends & family
Lower likelihood of marriage
Isolation or ostracism from family or community

Immediate Psychological Consequences:
Shock, denial, fear, confusion, anxiety, withdrawal, shame or guilt, nervousness, distrust of others, symptoms of post-traumatic stress disorder (emotional attachment, sleep disturbances, flashbacks, mental replay of assault

Associated Chronic Psychological Consequences:
Depression
Generalized Anxiety
Attempted or completed suicide
Post-traumatic stress disorder
Diminished interest/avoidance of sex
Low self-esteem/self-blame

<u>Associated Behavioral Health Risk:</u>
Unprotected sex
Early sexual initiation
Choosing unhealthy sexual partners
Survival Sex
Smoking, drinking and other drug use
Drinking and driving
Unhealthy diet-related behaviors (fasting, vomiting, abusing diet pills, overeating)
Failure to engage in healthy behaviors

Sexual Violence is a public health issue affecting millions throughout the United States Every 98 seconds, an American is sexually assaulted.

On average, there are 321,500 victims (age 12 or older) of rape and sexual assault each year in the United States

Your ability to recognize, respond, and refer will assist you in providing better care to your patients/clients, informing and connecting survivors of sexual victimization to the services available in Massachusetts.

Section III: Domestic Violence

Domestic Violence is a pattern of coercive behavior that one person uses to intentionally gain and maintain power and control over another in a close personal relationship. Abuse can happen in both romantic and non-romantic relationships and includes…Physical, emotional/psychological, sexual, financial, legal abuse, and threats based on one's culture or identity, and stalking

It is important to recognize that domestic violence occurs within a psycho-social context; hence definitions may vary across populations. Some populations experience domestic violence that involves multiple abusers, such as an extended family or crime networks. Domestic violence may occur outside the context of a romantic relationship, such as abuse by caregivers or siblings. For some populations, their experience of abuse also involves intentional neglect.
Nonetheless, regardless of the circumstances, the relationship between the abuser and the victim is always one in which the abuser holds the power

Greatest Risk for Domestic Violence

Any person, anywhere regardless of race, gender identity, sexual orientation, social class, educational background, ethnicity or religion is at risk for domestic violence. However,

research clearly indicates that adverse effects of intimate partner violence appear to be more prevalent in certain groups such as….

Women especially those who are single, separated, or divorced, Adolescents and young adults, people of color, immigrant women, lesbian, gay, bisexual, transgender, or gender non-conforming individuals

Section III: Domestic Violence - National Prevalence

Men & Women: 1 in 4 women and 1 in 9 men were victims of contact sexual violence including rape, sexual coercion, unwanted sexual contact, physical violence and or stalking by an intimate partner

Domestic Violence Prevalence among High Risk Populations

Lesbian, Gay, Bisexual, Transgender, and Queer: Nearly 1 in 3 lesbian women (29.4%), 1 in 2 bisexual women (49.3%), and 1 in 4 heterosexual women (23.6%) has experienced at least one form of severe physical violence by an intimate partner in her lifetime. Bisexual women experienced significantly higher prevalence of these types of severe violence compared to lesbian and heterosexual women. The difference between lesbian and heterosexual women was not statistically significant.

Four in 10 lesbian women (43.8%), 6 in 10 bisexual women (61.1%), and 1 in 3 heterosexual women (35.0%) reported experiencing rape, physical violence, and/or stalking within the context of an intimate partner relationship at least once. Bisexual women experienced significantly higher prevalence of these types of violence compared to lesbian and heterosexual women.

Approximately 1 in 4 gay men (26.0%), 4 in 10 bisexual men (37.3%), and more than 1 in 4 heterosexual men (29.0%) reported experiencing rape, physical violence, and/or stalking by an intimate partner during their lifetime. The differences between these groups of men were not statistically significant. The numbers of men who reported rape by an intimate partner among gay, bisexual, and heterosexual men in the United States are too small to report.

Low Income: Domestic Violence is a main cause of homelessness for women and children due to families fleeing an abusive relationship or being evicted because of the abuse present in the household. Women experiencing poverty experience domestic violence at higher rates than women with high incomes. Women living in rental housing experience intimate partner violence 3 times the rate of home owners. According to multiple studies examining the causes of homelessness, among mothers with children experiencing

homelessness, which revealed more than 80% had previously experienced domestic violence

Women with low incomes and women experiencing poverty are often trapped in abusive situations by lack of financial resources, lack of safe and affordable housing options or assistance, and discrimination against survivors. Lack of income and poverty limits victim's choices and creates additional barriers to leaving abusive relationships

Race & Ethnicity: Approximately 4 out of every 10 women of non-Hispanic Black or American Indian or Alaska Native (43.7% and 46.0%, respectively), and 1 in 2 multiracial non-Hispanic women (53.8%) , 1/3 of white women and more than 1/3 of Hispanic women have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

1/5 of Asian or Pacific Islander and 1/5 of non-Hispanic women have also reported having experienced rape, physical violence, and or stalking by an Intimate partner

Nearly half of American Indian or Alaska Native men (45.3%) and almost 4 out of every 10 Black and multiracial men (38.6% and 39.3%, respectively) have reported experiencing rape, physical violence and or stalking by an intimate partner during their lifetime. ¼ of Hispanic and ¼ of white non-Hispanic men have reported experiencing rape, physical violence and/or stalking by an intimate partner during their lifetime.

Immigrants & Non-English speaking:

Studies show that immigrant women and girls in the United States are twice as likely to experience domestic violence than the general population, and they're less likely to leave their abusers due to lack of financial resources, social isolation, and fear of immigration consequences, such as being separated from children, and deportation

Immigrant women often suffer higher rates of domestic violence than U.S. citizens because they may come from cultures that accept domestic violence or because they have less access to legal and social services than U.S. citizens. Additionally, immigrant perpetrators and victims may believe that the penalties and protections of the U.S. legal system do not apply to them

Abusers often use their partners' immigration status as a tool of control. In such situations, it is common for the abuser to exert control over his partner's immigration status in order to force her/him or them, to remain in the relationship.

For Domestic Violence prevalence information regarding additional high-risk populations please refer to the supplemental handouts

Section III: Domestic Violence - Associated Consequences

Red Flags:
Some survivors, with a current or history of abuse may show no obvious signs or symptoms of medical or psychological distress, some, however may present signs and symptoms known as the 'red flag'. No one red flag indictor necessarily indicates that one is experience IPV, indicates a need for follow up

Physical Trauma: delay in seeking care, acute injuries, particularly lacerations, contusions, dislocations, fractures, head injury, or findings consistent with attempted strangulation

Strangulation Injuries: Visible signs of strangulation may be far more difficult to detect in darker skinned patient than those with fairer skin tones

Gynecological Problems: Genital lacerations and contusions, sexually transmitted infections (including HIV), rape and sexual assault, unintended pregnancy, rapid repeat pregnancy, abortion complications

Somatic Disorders: Headaches, chest pain, abdominal pain, pelvic pain, back pain, fatigue, eating disorders, functional gastrointestinal disorders

Medical History: old unexplained injuries, high stress in family, "accident prone" patient, unintended pregnancy and rapid, repeat pregnancies, frequent emergency department, urgent care, or office visits

Localized or Generalized Neurological Findings: Altered mental status, seizures, motor or sensory deficits, memory problems

Behavioral/Psychiatric Issues: Anxiety, Depression, hypervigilance, panic, dissociation during medical procedures, history of suicidal ideation or attempts, substance use

Social 'Red' Flags: Frequent missed appointments, delayed presentation for care, seeming "non-compliance" with Medical Instructions

Partner Red Flags: When the partner insists on accompanying the client/patient into the exam room, when the partner answers all the questions or speaks for the client/patient or when the patient/client turns to their partner for approval when answering questions.

Associated General Health Conditions

Asthma
Bladder and kidney infections
Circulatory conditions
Cardiovascular disease
Fibromyalgia
Irritable bowel syndrome
Chronic pain syndromes
Central nervous system disorders
Gastrointestinal disorders
Joint disease
Migraines and headaches

Social

Restricted access to services
Strained relationships with health and mental healthcare providers and employers
Isolation from social networks
Homelessness

Associated Psychological Consequences

Anxiety
Depression
Symptoms of post-traumatic stress disorder (PTSD)
Antisocial behavior
Suicidal behavior in females
Low self-esteem
Inability to trust others, especially in intimate relationships
Fear of intimacy
Emotional detachment
Sleep disturbances
Flashbacks
Replaying assault in the mind

Associated Health Risk

Alcohol and other drug dependency
Obesity
Practice of risky sex behaviors
STI's including HIV

Associated Reproductive Health Conditions

Gynecological disorder
Pelvic inflammatory disease

Sexual dysfunction
Sexually transmitted infections, including HIV
Delayed prenatal care
Preterm delivery
Pregnancy difficulties like low birth weight babies and perinatal deaths
Unintended pregnancy

For more information on Sexual and Reproductive Coercion please refer to the supplemental handouts

Section III: Domestic Violence: Barriers to Leaving & DV and Special Populations

Barriers to Leaving:

Leaving is often the most dangerous time for a victim of abuse; since abuse is about power and control when the victim leaves, they are taking control and threatening the abusive partner's power, which could cause the abuser to respond in more harmful and destructive ways. This is not an exhaustive list, for there are countless reasons that may serve as a barrier to leaving an abusive relationship.

Fear
Believing abuse is normal
Fear of being outed
Embarrassment or Shame
Beliefs about Themselves
Beliefs about the Abuser
Cultural/Religious Beliefs
Language Barriers
Immigration Status
Victim is dependent on Abuser for money, food, and or shelter
Lack of Money
Lack of Resources
Lack of Support/Isolation

Other forms of Domestic Violence

Elder Abuse:

Another form of Domestic Violence is Elder Abuse
Elder Abuse is an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult. (An older adult is defined as someone age 60 or older.) Forms of elder abuse

are physical abuse, sexual abuse including sexual coercion, emotional/psychological abuse, economic abuse, neglect, financial and exploitation

Why are elders a target
Many seniors do not realize the value of their assets
The elderly are also likely to have disabilities that make them dependent on others for help
They may have predictable patterns and
Severely impaired individuals are less likely to take action against their abusers as a result of illness, ability, fear or embarrassment

For more detailed information on Elder Abuse including risk factors for perpetration and victimization please refer to the supporting documents and links

IPV in Marginalized Communities:

Every culture has elements that *condone* intimate partner violence…
…and elements that resist it.
When we are referring to culture, we are not just making inference to race, ethnicity, nationality and religion but we are including other attributes such as gender, age, language, sexual orientation, faith practices, attitudes

Culture does not explain nor justify abuse

Children Exposed to Domestic Violence

Children are affected by IPV regardless if the abuse witnessed is a physical assault children can be exposed to IPV in a number of ways whether they overhear one caregiver/partner threaten the other, witness a parent who is out of control, riddled with anger, observe one partner and or parent assault the other, or live with the aftermath of a violent assault.

There is a correlation between children exposed to IPV and child abuse…children who live in an environment where IPV is present are at an increased risk of becoming direct victims of child abuse

IPV poses a serious threat to the emotional, psychological and physical well-being of a child. Not all children exposed to IPV are affected the same this is particularly so if the violence is chronic

Short term effects include generalized anxiety, sleeplessness, nightmares, difficulty concentrating, high activity levels, increased activity, increased aggression, increased

anxiety about being separated from a parent, intense worry about their safety or the a parent

Long term effects include

Behavior problems in adolescence: e.g. juvenile delinquency, alcohol or other substance abuse

Emotional difficulties in adulthood e.g. depression, anxiety disorder, PTSD

More likely to become victims of dating violence: believing that violence is somehow linked to expressions of intimacy, affection and or love

Unhealthy lessons around power and control in relationships may be adopted. (same example as above) as well as learning to exert control or to use violence as an appropriate method of relieving stress

Section IV: People who use violence

Things to keep in mind…
1) Sexual Assault is a crime regardless of the relationship between the victim and the perpetrator
2) Between 2/3 and ¾ of sexual assaults are planned in advance with most perpetrators are known to their victims

People who perpetrate sexual violence….

1) have normal personalities with tendencies to be aggressive and violent
2) are experts in rationalizing their behaviors
3) have no “typical” profile (place focus on their behavior not who they are)

4) use sex to inflict pain, power and control

5) don’t typically have an impulsive sexual desire

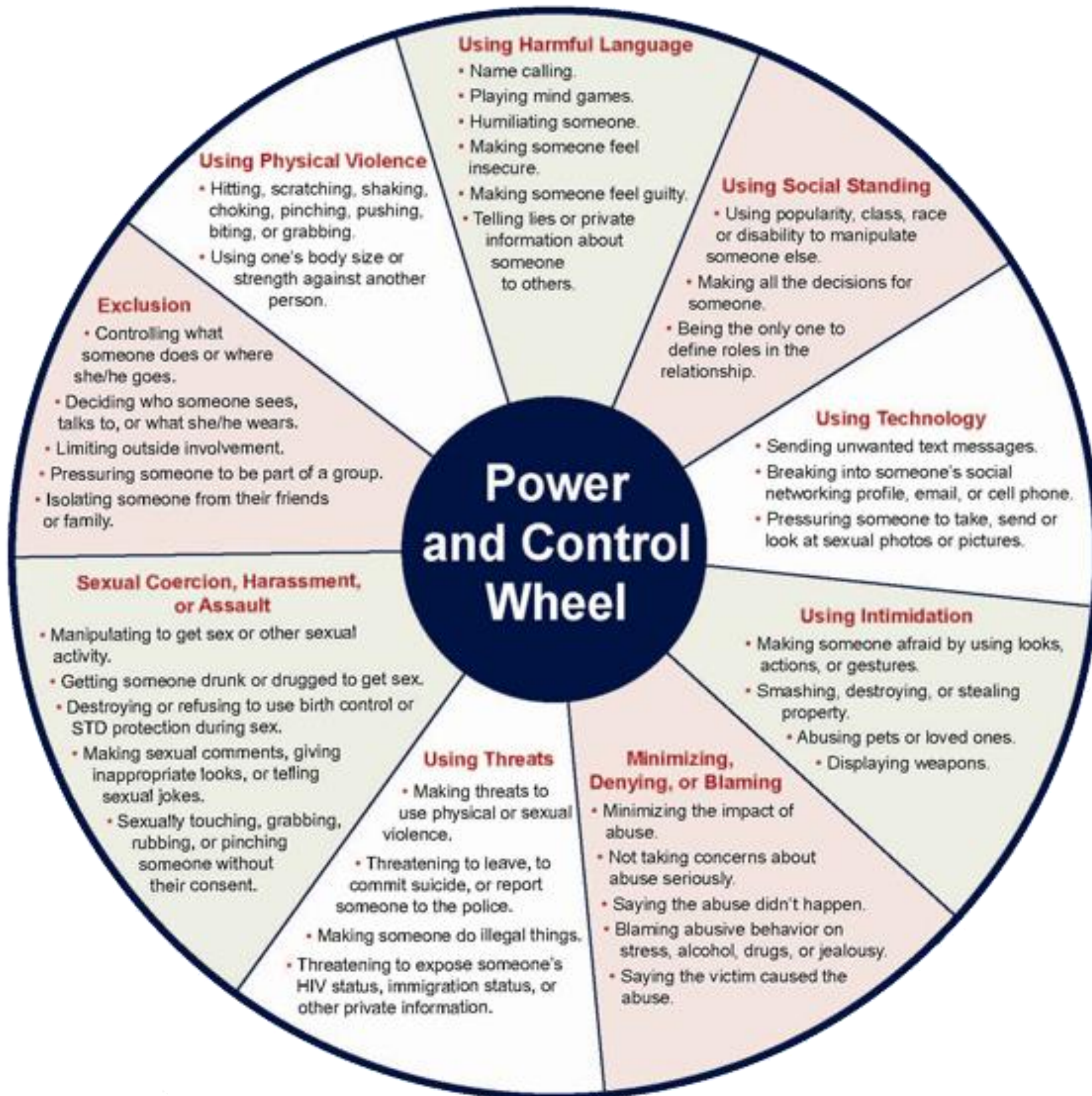
6) don’t typically present as mean or menacing

7) Sexual violence is often a part of intimate partner violence

People who perpetrate Domestic Violence

"For many years practitioners have used the "Power and Control Wheel" to understand the different tactics used by perpetrators of domestic violence. As you can see, power and control is at the center and there are various categories of abuse that can be employed. Only one set of tactics includes physical violence as many other tactics can also be employed to maintain control in a relationship…"

These tactics include:



As part of your work in support of survivors it is important for you to be aware of what survivors may be experiencing. We are not asking for you to screen for perpetration, however during your practice you may receive some disclosures.

It is important to note….

- Intimate Partner Violence is Purposeful…
  People who use IPV
  - Use a variety of tactics based on what they want to accomplish and what will work
  - Are strategic about their use of violence, and are not violent all the time
  - May involve others in the abuse person using the violence may involve other in their abuse such as children
  - Escalate control tactics as needed, to maintain control, often at key points in the relationship
  - Retaliate when victims seek help or end the relationship
  - Deny, minimize, and blame the victim for their abuse
  - May use stigma to undermine and control and
  - Can use their own mental health or substance use to rationalize their abuse
  - Abuse is not typically an isolated event but is perpetrated in a variety of ways (see the Power and Control Wheel).

Things to keep in mind….
People who use violence may

threaten to withhold money or resources that the survivor has become accustomed to;

have connections to powerful people in the community that make it difficult for the survivor to access or utilize traditional resources safely

limit their partners access to learn English, thereby creating a barrier to accessing appropriate services

use gender pronouns that are contradictory to how their partner Identities themselves and or they may threaten to "out" their partner's sexual orientation

Immigrant survivors are often threatened by their partners with deportation

Many immigrant survivors don't report sexual assault or intimate partner violence to law enforcement, out of fear of deportation

Many survivors from marginalized communities will not report to law enforcement due to historical and institutional racism law enforcement has held toward various communities

People who perpetrate Elder Abuse

Red Flags from Nursing Home Staff
When staff prevents elder from receiving visitors or speaking
Lack of affection toward elder
Conflicting accounts regarding incidents involving Nursing home staff and residents
Speak of elder as a burden
Flirtation or coyness from Nursing Home staff toward residents