Domestic & Sexual Abuse: What Healthcare Providers Need to Know

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Disclosure

• I serve as the Program Manager for the Domestic Violence/Sexual Assault Program at Newton-Wellesley Hospital
• I am not here today in that capacity
• I am here today as an independent trainer/consultant

Objectives

• Section One: Definitions and Dynamics of Domestic Abuse
  • Abuser tactics, Abuser psychology, Survivor psychology, Barriers to leaving
• Section Two: The Role of Providers
  • Universal Education and Assessment
  • Responding (including safety planning)
  • Documenting
Objectives

• Section Three: Defining Sexual Violence and Understanding the Emergency Response
• Section Four: Children’s Exposure to Violence/Abuse
  • Mandated Reporting
  • Health Impact of Exposure
• Section Five: The Role of Providers Regarding Violence and Abuse More Broadly
  • Health consequences of lifetime exposures to violence and abuse (COLVEA)

Violence and Abuse are Massive Public Health Issues

• 1 in 6 boys will be sexually assaulted or sexually abused before the age of 18
• 1 in 3 girls will be sexually assaulted and/or experience teen dating violence before the age of 18
• 1 in 4 women & LGB individuals will experience abuse at the hands of a partner in adulthood
• People with disabilities (including mental health and addiction challenges), people who are undocumented, people who are gender non-conforming, and people who are homeless (amongst others) experience disproportionate rates of violence and abuse

SECTION ONE:
DEFINITION AND DYNAMICS OF ABUSE

- Definitions and Dynamics of Domestic Abuse (aka the basics of Intimate Partner Abuse)
  - Tactics Used by People Who Choose to Be Abusive
  - Survivor Psychology
  - Barriers To Leaving
Intimate Partner Abuse (IPA) – The Basics

- Intimate partner abuse is a **pattern** of coercive, manipulative or controlling behaviors that serves to **isolate** or instill fear.
- Verbal/Emotional
- Mental
- Financial
- Cultural/Identity
- Use of Children as Proxies, Weapons (also Elders, Pets)
- Physical
- Sexual

What is the picture in your head of people who use abusive behaviors?

Reality

- Most people who use abusive behaviors are never identified
- Most project a different face to the outside world than they do to their families or the people they are abusing
- Only a small proportion are ever arrested (and an even smaller proportion convicted)
IPV – “Crazy Making” and Trauma Processing

**Crazy Making**
- Denial: It didn’t happen. Maybe I just imagined it.
- Minimization: It wasn’t a big deal, nothing happened.
- Externalization: They were drunk or under stress.
- Blame: They must have done it to you.

**Crazy Making** - The abusive person will attempt to confuse and obfuscate the situation in order to convince the survivor and others that the survivor is at fault.

**Trauma Processing**
- Denial: It didn’t happen. Maybe I just imagined it.
- Minimization: It wasn’t a big deal, nothing happened.
- Externalization: They were drunk or under stress.
- Blame: They must have done it to you.

**Trauma Processing** - The survivor will sometimes do this in order to survive emotionally and to protect their safety.
Why Don’t They Leave?

• The question itself is harmful, damaging
• What are some of the questions we could/should be asking instead?
  • Why does the abusive person keep choosing to be abusive?
  • What is keeping the survivor trapped and what can we do to ensure, empower her/his/their safety?
  • Why do we allow the abusive person to keep being abusive?

What Keeps Survivors Trapped?

• Fear of retaliation by abuser or others
• Loss of income, home, benefits or immigration status for self or children
• Love, hope, confusion, shame, belief that the abuse is their fault
• Lack of information, lack of awareness of legal rights, other resources
• Victim-blaming, lack of offender accountability
• Financial, physical, or social dependence on abuser (or vice versa)
• Societal/family pressure to keep relationship and/or family together
• Fears and barriers related to racism, homo/bi/transphobia, ableism, etc.
• Compromised health or trauma-related issues

SECTION TWO:
THE ROLE OF PROVIDERS

- The Role of Providers
- Universal Education and Assessment
- Don’t Ask, Tell!
- Responding (Including Safety Planning)
- Documenting
Universal Education: Why Educate?

• Routine education coupled with direct assessment serves as an important strategy for preventing and identifying all forms of abuse. (Don't ask, Tell!)
• It is now considered best practice to universally educate all patients about healthy relationships, coercion, consent, and even safe bystander interventions in the event that unhealthy or disrespectful behaviors are witnessed by the patient.
• Survivors often choose not to disclose, and therefore assessing alone is a lost opportunity for sharing information and resources that may increase safety and improve clinical outcomes.

Universal Education

• Universal Education can be accomplished in a number of ways: Create an environment where information, including hotline numbers, safety cards, and resource cards on about violence, abuse and neglect are prominently displayed in common areas, as well as in private areas, such as bathrooms and exam rooms.
• Ensure resources in lobbies, exam rooms, bathrooms, etc. that address the health impact of violence, abuse, and neglect.

Universal Education

• Ensure that all staff model healthy, respectful behavior to patients, visitors, and to one another.
• Ensure that all staff have received training and are comfortable discussing violence, abuse and neglect with their patients and co-workers.
• Ensure that patients have ample opportunities to talk about healthy relationships/behaviors during visits.
Universal Education

- Provide brief in-person education to all patients about the signs of an unhealthy relationship, as well as what they can do if they have a friend or family member who is struggling with abuse.
- Plant seeds for patients not yet ready to disclose.

Assessment: Why Assess for Domestic Abuse?

- Allows for accurate diagnosis
- Allows for early diagnosis and (hopefully) prevention
- Knowledge of domestic & sexual abuse should inform and in some cases guide treatment
- May be important in detecting seemingly unrelated sequelae months later
- Protects children by empowering their protective parent
- Creates a safe space for survivors to return to months, even years later

Brief Guidance on Assessing, Intervening, Documenting

- Be proactive about cultivating relationships with your local domestic abuse organization
  - JaneDoe.org - Interactive tool to locate your locate sexual and domestic abuse programs
- See handout for additional specific guidance
Primary Goals of Intervention

- Safety, safety, safety, and safety
- We are not to determine what is and is not safe; the survivor alone determines what is safe
- Assisting the survivor to transcend the experience of isolation
  - “I am so glad you told me.”
  - “You are not alone.”
  - “Thank you for telling me.”

Redefining “Success”

- It is counterproductive for the health care provider to define “success” as getting a survivor into a shelter that night, or making the survivor leave their partner today.

As John Fazio, chief nurse at San Francisco General Hospital, says when training his peers, “She has been dealing with domestic violence for 15 years, and you’ve known her for 10 minutes. Who is more qualified to make a good decision for your patient – you or she?”

Principles for Safety Planning

- **What has worked** for the survivor in past?
- Understand that **safety planning is a process, not an event**. You are (most likely) just the beginning of the plan.
- **Collaboratively plan** around the one or two concrete things which cause the survivor the most fear.
- When they envision exercising a choice (restraining order, shelter, privately speaking with an attorney, waiting), **what do they think is the safest thing to do?**
Principles for Safety Planning

• Remember: compliance is a superb safety strategy, esp. in the short term.
• Safety planning is individualized. It looks different for different people in different communities.
• The National Center on Domestic & Sexual Violence has a wealth of different safety plans in different languages:
  • http://www.ncdsv.org/publications_safetyplans.html
  • This includes safety plans for teens, for transgender survivors, older survivors, survivors of stalking, for people in the military, safety planning around technology, etc.

SECTION THREE:
SEXUAL ABUSE

Defining Sexual Abuse and Understanding the Emergency Response

Defining Sexual Abuse

Sexual violence or sexual assault is any sexual attention, contact, or activity that is one or more of the following:
• Unwanted
• Coerced
• Committed without consent
• Forced either by physical means or by threat

➢ Sexual abuse is a term covering a wide range of unwanted sexual contact or behavior including sexual abuse, rape, attempted rape, incest, exhibitionism, voyeuring, fondling, sexual harassment, and obscene phone calls/texts.

➢ Sexual violence is commonly motivated by a desire for power and control of the survivor and is perpetrated through the use of sexual means.
Sexual Violence - Prevalence Rates

1 in 4 women report experiencing sexual assault or abuse in their lifetime.
1 in 6 men report an experience of sexual assault or abuse in childhood; 1 in 59 men report being raped in their lifetime.
Evidence indicates that lesbian, gay and in particular bisexual and transgender populations experience disproportionate rates of sexual violence across the lifespan compared to their straight and cisgender counterparts.
People who use sexually abusive tactics often target individuals who are survivors of multiple traumas.

Universal Education, but Not Assessment

• We do not currently recommend screening for sexual violence, absent indicators.
• Please assess in response to indicators, however.

Role of the Provider in Response to Disclosures

• Safety
• Empowerment
• Empathy
• Knowledge

Boston Area Rape Crisis Center
Sexual Assault: The Emergency Response

- MA Sexual Assault Nurse Examiner (SANE) Program – accessed through emergency departments in SANE-participating hospitals
- Specially trained providers certified in forensic medical-legal exams
- Adult-adolescent exams and post-exposure prophylaxis up to 120 hours post-assault
- Acute (vs. chronic) pediatric assault up to 72 hours

Sexual Assault: The Emergency Response

- Provision of immediate necessary medical care
- Evidence collection
- Provision of post-exposure prophylaxis for STIs and, where relevant, pregnancy prevention
- Bridge to follow-up infectious disease care
- Connection to a specialized sexual assault advocate
  - Counseling, legal, advocacy, emergency financial assistance (esp around PEP), assistance with ‘billing safety’

SECTION FOUR: CHILDREN’S EXPOSURE

- Children’s Exposure to Violence and Abuse
- Mandated Reporting: When to Do It and How to Do It Safely
- Recognizing the Health Impact
Mandated Reporting

- Witnessing domestic abuse is not mandated reporting except under the following circumstances:
  - Child has been directly abused or injured
  - The person using abusive behaviors threatens homicide/suicide and the survivor fears for children's safety
  - The person using abusive behaviors has used or threatened to use a weapon and survivor believes that that person is capable of doing so
  - The person using abusive behaviors has forced child to observe or participate in the abuse
  - Everything outside of this falls under the clinical judgment of the provider
  - Consider the impact on the child

How to Report Safely

- Recognize that the best interests of the protective parent and the best interests of the child(ren) are one and the same
- Recognize that, in most cases, the safety of the children is best secured by empowering the protective parent to craft and execute their own strategy for managing the abusing individual’s behavior

How to Report Safely

- Recognize that leaving the abusive household likely increases the danger to the children/elders/pets and the survivor in the short term (12-24 months, sometimes longer)
- Work from a strength-based (vs. deficit) framework
How to Report Safely

• Understand that reporting may well be used as a pretext to escalate by the person using abusive behaviors, and therefore danger to the children may escalate
• Inform the protective parent in advance of the need to file
• Ask the protective parent to file with you
• Collaboratively craft a safety plan with the protective parent
• Alert DCF to any safety concerns that the report raises for the survivor (children, dependent elders, pets, DCF worker)

How to Report Safely

• Safety plan with children in age-appropriate fashion and with protective parent’s guidance and participation
• *Note: This may not necessarily mean informing the children about the report
• File on behalf of the children, not against the family or the survivor
• Contact a domestic abuse program for assistance
• Objectively document the disclosures of the protective parent

Maximizing Safety When a Report is Necessary

• Provide DCF with as much information as you can about the risk factors posed by the person using abusive behaviors:
  • Prior threats made (including homicide, suicide, parental kidnapping)
  • Access to weapons
  • Escalation in violence over prior 12 months
  • Drug/alcohol use
  • Stalking behaviors
  • Employment (or lack thereof)
  • Special training/skills (Law enforcement, military, etc)
Suggestions for Counseling Protective Parents
• Self-care, self-care, self-care
• Treat children equally and with respect
• Teach non-violent conflict resolution
• Intervene when children are not treating one another with respect
• Help children explore their feelings
• Help children to think critically

Suggestions for Counseling Protective Parents
• Educate children about dynamics of abuse, again in age-appropriate fashion
• Educate children about post traumatic stress
• Build connection to safe people, to creativity, to nature, to community

The National Child Traumatic Stress Network has a series of tip sheets for protective parents surviving domestic abuse

SECTION FIVE: TRAUMA-INFORMED CARE
The Role of Providers Regarding Violence and Abuse More Broadly: Trauma-Informed Care and the Adverse Childhood Experiences Study (ACEs)
Origins of ACEs

- Kaiser Permanente & the CDC, 1994
- Drs. Vince Felitti & Robert Anda
- Grew out of work Dr. Felitti did with people who were morbidly obese
  - The most successful patients (i.e., those who succeeded in losing the largest amounts of weight), were also those most likely to fail out before the target weight was achieved.

ACEs Design

- Sample size: 17,000+ Americans
- Ten-year long, retrospective (and ongoing) study looking at the effect of traumatic experiences during the first 18 years of life on adolescent and adult medical and mental health and life expectancy.
- Study discovered that adverse childhood experiences had enormous lifelong health impact

Measures of Adverse Childhood Experiences

- 10 categories of adverse experiences
  - Emotional Abuse
  - Physical Abuse
  - Sexual Abuse
  - Witnessing (step)mother being treated violently
  - Household member with an MH challenge
  - Household member had a substance abuse challenge
  - Household member was imprisoned
  - Not being raised by both bio parents
    - Later added:
      - Emotional neglect
      - Physical neglect
The Three Cs

- The study found that adverse childhood experiences were:
  - Common
  - Frequently co-occurring
  - The impact of these exposures was cumulative

Questions??

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