NATIONAL Center on Domestic Violence, Trauma & Mental Health

Responding to Intimate Partner Violence in Clinical Settings: a Trauma-Informed Approach

Carole Warshaw MD
Director, National Center on Domestic Violence, Trauma & Mental Health

Bluegrass Care Clinic Webinar
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Webinar Objectives

At the end of this webinar you will be able to:

- Describe a framework for thinking about trauma in the context of IPV
- Discuss current research on the prevalence and impact of IPV and other trauma with specific attention to the impact on people living with HIV/ AIDS
- Describe the neurobiology of trauma and its implications for clinical practice
- Describe initial strategies for implementing a trauma-informed approach to IPV.

But first, take a moment..

Framing the Issues:

Why Address IPV and Other Trauma in HIV Treatment Settings?

What Do We Mean by Intimate Partner Violence (IPV)?

- IPV is a **pattern of assaultive and coercive behaviors** designed to **dominate and control** a partner through **fear and intimidation.** This can take the form of **physical, sexual, emotional**, and/or **economic abuse, isolation, deprivation, and stalking, as well as coercion and threats**.
  - These can include emotional manipulation of children, threats related to deportation or child custody, and outing a partner's gender identity or sexual orientation as well as abuse targeted toward a partner's health, mental health, wellbeing, and access to care.
- These behaviors **result in physical and psychological harm**

Ganley, 1995, NCDVTMH 2017

What Do We Mean by Trauma?

Individual Trauma: The unique individual experience of an event, series of events or set of circumstances

- Experienced by an individual as physically or emotionally harmful or life threatening
- Has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
- The individual's coping capacity and/or ability to integrate their emotional experience is overwhelmed causing significant distress.

Collective Trauma: Cultural, historical, insidious and political/economic trauma that impacts individuals and communities across generations

Interpersonal Trauma: Intimate and social betrayal; Cumulative burden; Ongoing risk

Packard, NIWRC 2014, SAMHSA, 2014, NCDVTMH 2012, Van der Kolk 2003

IPV and Trauma in a Broader Social Context

Warshaw 2015

Why a Culturally Responsive, IPV- and Trauma-Informed Approach?

- IPV and trauma are pervasive and have significant health, MH and SU-related effects
- People who access health, MH and SUD Tx services experience high rates of IPV and other trauma.
- People who abuse their partners actively use health, MH and substance use issues against their partners as a tactic of control
- Trauma and IPV affect people's access to and experiences of health care

Why a Culturally Responsive, IPV- and Trauma-Informed Approach?

How we respond and the environments we create make a difference.

- When we are able to respond in culturally resonant, IPV- and trauma-sensitive ways, people feel safer talking about their experiences and are more likely to find treatment helpful.
- As health care providers, we are also affected by trauma and need to be supported in addressing our own feelings if we are to remain open and responsive to the experiences of our patients
- Creating organizational culture that supports a welcoming, inclusive, IPV- and trauma-informed approach is essential to the provision of optimal care

What Do We Know About the Prevalence and Impact of Intimate Partner Violence?

Prevalence of Intimate Partner Violence and Sexual Violence in the U.S.

- **Lifetime IPV Rape, Stalking or Physical Victimization**
  - 35.6% of women; 28.5% of men
- **Rates are as high or higher among people who are lesbian, gay and bisexual**
  - 43.8% of lesbian women; 61.1% of bisexual women; 26.0% of gay men; 37.3% of bisexual men;* 25%-54% trans individuals**
- Rates are **highest** among **American Indian and Alaska Native women.**
- **Women more likely to experience multiple forms of IPV.** Men primarily experience physical violence
- **Women are more severely affected**

*-Black et. al. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention;** James et al., 2016

High Rates of Abuse and Violence Among Women Living with HIV

- 61.1% lifetime sexual assault – five times the rate seen in the general population
- 55.3% IPV, almost twice the rate reported in a national sample of women
- 39.3% childhood sexual abuse, more than twice the rate in the general population
- Estimated rate of lifetime abuse among WLHIV is 71.6%, compared to 39% in a national sample

Matchinger et. al., 2012, Neti, 2005, Pence et al., 2002, Cohen, et al., 2004

High Rates of Trauma and IPV Among People Seen in HC Settings

- **IPV in Family Medicine Settings**
  - Past Year 19.9%
  - Lifetime: 38.0%
- **IPV in Emergency Medicine Settings**
  - Past Year: 19.5%
  - Lifetime: 40.0%
- **ACE Study:** N = 17,377
  - 10 Categories of childhood trauma: 63% at least one; 25% two or more; 20% >3
- **Trauma in Urban Primary Care Settings:** N=509
  - Lifetime 79.0%; 65% exposed to >1

Sprague et al., 2014, Liebschutz et al., 2007. Felitti et al 1998, Dube et al 2001, 2012, Weigh et al. 2010

IPV Survivors Experience Higher Rates of…

- Injuries, headaches and chronic pain
- Asthma, diabetes, and irritable bowel syndrome
- Activity limitations and sleep difficulties
- STDs, HIV, unplanned pregnancy and pregnancy complications, including HTN, edema, UTI, bleeding, Pre-term labor, LBW, N&V, NICU, homicide
- Poor physical and mental health
- Stress-related symptoms, unexplained injuries, repeat visits, delays in seeking care, overly protective or controlling partners

Black et al 2011. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. http://www.cdc.gov/violenceprevention/nisvs/
Maternal and Infant Health Assessment, California Department of Health Services, Maternal, Child and Adolescent Healthy Office of Family Planning Branch, 2004; Miller et al 2009; Silverman et al., 2006; Shadigan et al., 2005

Experiencing gender-based violence places women at greater risk for acquiring HIV, and for more rapid disease progression, reduced medication adherence, and more frequent hospitalization.

IPV Survivors Experience Abuse Specifically Targeted Toward their Health and Health Care

- **Undermining Health and Wellbeing**
  - Interfering with sleep, bodily functions, medication, diet
  - Sabotaging treatment and recovery
- **Interfering with Health Care Access**
  - Controlling transportation, funds, insurance
- **Reproductive Coercion**
  - Coerced pregnancy: Birth control sabotage
  - Coerced termination of pregnancy; Injury-related miscarriage
  - STIs & HIV/AIDS: Threats and violence associated with condom negotiation and partner notification

Mental Health and Substance Use Consequences of IPV

IPV Increases Women's Risk for Depression, PTSD and Suicide

Diagnosis	Prevalence*
Depression	50.0%
PTSD	61.0%
Suicidality	20.3% (53.6%)**

and, for Self-harm, Anxiety & Eating Disorders & SUDs

*Weighted mean prevalence across studies. Rates differ by setting.
- In shelters, Depression = 63.8%, PTSD = 66.9%, Suicidality = 29.6%.
- For court-involved women, Depression = 73.7%
- In mental health settings, Suicidality = 53.6%
- IPV also increases risk for post-partum depression

Golding, 2000; Weigh et. al., 2010; Rees et. al., 2011; Black et. al., 2011, Oram et. al., 2014

HIV, IPV and Mental Health

- WLHIV who experience IPV compared to HIV-negative women who have not experienced IPV:
  - 5x more likely to report symptoms or anxiety
  - 7x more likely to report problems with depression
  - 12.5 x more likely to report having attempted suicide
- Chronic depression, stressful events, and trauma associated with:
  - More rapid HIV disease progression
  - Decreased likelihood of following prescribed treatment regimens.

Abuse and Violence Across the Lifespan

Play a Critical Role in the Development and Exacerbation of Mental Health & Substance Use Disorders

Survivors of IPV Often Experience Multiple Types of Trauma

- Significant proportion of IPV survivors have experienced multiple types of trauma, including collective and historical trauma
- Gender-based violence increases risk for mental health and substance abuse conditions
  - 89%of women who experience 3-4 types of GBV develop a diagnosable mental health condition
- Discrimination, including racism and homo/transphobia, historical trauma and deportation fears increase the risk for developing PTSD and other MH and SU conditions
- Abuse in childhood increases the risk for adult victimization and for the development of a range of health, MH and SU conditions.

Rees et al., 2011, Kessler & Bieschke 1999, Arata1999, Breslau et al.,1999, Astin et al.,1995

LGBTQ Survivors of IPV: Multiple Types of Trauma; Constrained Choices

- LGBTQ IPV often occurs in a landscape that includes other forms of abuse and trauma, including **family violence, sexual violence, hate crimes, and police brutality.**
- May be subject to abuse by multiple perpetrators and at multiple points in time.
- LGBTQ survivors may be forced to make constrained choices about safety, often trading one kind of safety for another.

Milller et al., 2017

Adverse Childhood Experiences Study

N=9,508 &17,337 Adults in HMO

Physical, Sexual, Psychological abuse & neglect, Witness violence toward mother, Household members with substance abuse, Suicide Attempts or Incarceration, Loss of parent (separation/divorce)

- **Dose response between # of experiences &:**
  - Alcoholism, Drug abuse, Depression, Smoking, IPV
  - Poor health, 50 or more sexual partners, unintended pregnancy, obesity and physical inactivity, increased prescriptions (psychotropics, bronchodilators)
  - IHD, CA, liver disease, skeletal fractures, COPD, lung CA
  - High perceived stress, headaches, impaired job performance, relationship problems, premature mortality
  - Psychiatric hospitalization, suicide attempts, hallucinations
  - Any ACE increased suicide risk by 2-5X

Felitti et al 1998, Dube et al 2001, 2012, Weigh et al. 2010

At the same time…..

Experiencing a Mental Health or Substance Abuse Condition Puts Women at Greater Risk for Being Abused

High Risk for Abuse Among Women Receiving Mental Health Services

Type of Abuse	OP Prevalence	MI
Adult physical	42%-64%	87%
Adult sexual	21%-41%	76%
Child physical	35%-59%	87%
Child sexual	42%-45%	65%

Women living with chronic mental illness experience higher rates of abuse. Women abused in childhood experience higher rates of psychiatric symptoms, homelessness and sexual assault as adults. Women in inpatient settings experience high rates of DV. Across studies, **lifetime prevalence rates average 30% OP, 33% inpatient, 60% psychiatric ER. Cross-setting studies have found current abuse rates of 26% and past year rates of 16%**

Jacobson 89, Lipschitz et al 96, Goodman et al 95, Friedman 2007, Cluss et al 2010, Oram 2013

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Mental Health Challenges and Resilience Among LGBTQ people

- Mental health difficulties are major concerns among LGBTQ people in general.
- Higher rates of trauma and potentially greater risk for PTSD, depression, and anxiety, isolation and suicidality
- Intensified for LGBTQ survivors of IPV, especially transgender individuals and survivors of color.
- Strength and resilience via identity affirmation and social support.

Milller et al., 2017

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High Risk for IPV Among Women in SUD Treatment

- **Higher Rates of Substance Use Among Survivors of IPV**
  - Rates of substance use 2x-6x as high; Range from 18%-72%
- **High Rates of of IPV Among Women in Substance Use Treatment Settings**
  - 47%-90% lifetime DV
  - 31%-67% past year
- **Self-medication common**
- **May be coerced into using**

Black et al., 2011; Breiding et al., 2014; Schneider & Burnett, 2009; Engstrom et al., 2012, Downs, 2001, Angerson, 2002; Gonomi et al., 2006; Eby, 2004; Smith et al., 2012; LaFlair et al, 2012; Nathanson et al, 2012, SAMHSA 2014; Rivera et al, 2016

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SAVA Syndemic: Substance Abuse, Violence and AIDS

- Substance abuse, IPV and AIDS frequently co-occur, each amplifying the effects of the other
- Alcohol and other substances are often used to cope with or manage symptoms associated with abuse and trauma
- Women with substance use disorders are at elevated risk for violence, abuse and coercion by intimate partners. Substance use among gay men associated with IPV and HIV.
- May result from direct effects of substances on decision-making and on the ability to negotiate safety in relationships.
- Once addicted, women may exchange sex for drugs, as a coping mechanism, or as a survival strategy, or resulting from direct coercion.
- They may also be coerced into engaging in unprotected sex or into sharing needles – all factors that increase a woman's risk for acquiring HIV and sexually transmitted infections.

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How Does this Work? Risk vs. Vulnerability

- **People who perpetrate DV use MH & substance use issues to control their partners**
  - Control of meds; Control of treatment
  - Coerced overdose; Commitment
  - Coerced use of substances; Control supply; Coerced illegal activity; Coerced sex
  - Undermining sanity, credibility, parenting & recovery
  - "She was out of control"

- **Stigma, poverty, discrimination & institutionalization compound these risks**

WHY DOES THIS WORK?

- Reports of abuse attributed to delusions
- Symptoms of trauma misdx as MI
- Assumptions that MI precludes good parenting
- Internalized stigma

Warshaw 2009

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Mental Health Coercion Survey

N=2,733

86%	Ever **called "crazy"** or accused of being crazy
74%	Deliberately did things to **make you feel like you are going "crazy"** or losing your mind
50%	Partner or ex ever **threatened to report to authorities that you are "crazy"** to keep you from getting something you want or need (e.g., custody of children, medication, a PO
53%	Ever **sought help for feeling upset or depressed**
49%	***If "yes"*** Has your partner or ex- **tried to prevent or discourage from getting** that help or taking prescribed meds for those feelings

Warshaw, Lyon, Bland, Phillips, Hooper NCDVTMH/NDVH 2013

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Substance Abuse Coercion Survey

N = 3,224

- **27%** — **Pressured or forced to use** alcohol or other drugs, or made to use more than wanted?
- **37.5%** — **Threatened to report** alcohol or other drug use to someone in authority to keep you from getting something you wanted or needed
- **24.4%** — **Afraid to call the police** for help because partner said they wouldn't believe you because of using, or you would be arrested for being under the influence?
- **26%** — Ever **used substances to reduce pain** of partner abuse?
- **15.2%** — **Tried to get help** for substance use?
- **60.1%** — **If yes,** partner or ex-partner **tried to prevent or discourage you from getting that help**

Warshaw, Lyon, Bland, Phillips, Hooper NCDVTMH/NDVH 2013

IPV Can Also Impact Children and Parenting

- Abusers actively try to undermine their partners' relationships with their children. This can compromise children's primary source of safety and protection and create risks for children's health, mental health and development
- Research consistently shows that secure attachment to the non-abusive primary caregiver is what is most protective of children's resilience and often the most important resource for children's recovery from traumatic stress.

Blumenfeld, 2014; Bancroft 2009, Van Horn/DVMHPI 2008; Wyman et al., (1999) Graham-Bermann, S. & Levendosky, A. (Eds.) (2011). Osofsky, J. D. (1999).

Trauma in the Context of IPV: Complex Picture

- Psychophysiological effects of trauma
- Direct effects of abuser behavior
- Survival strategies
- Exacerbation of prior health, mental health and substance use conditions
- Active undermining of parenting, recovery, economic independence, and social support
- Role of stigma and provider, institutional, societal responses, and limited resources
- Personal, cultural, spiritual sources of resilience and access to resources, remedies and support

Impact of IPV on Engagement in Care for WLHIV

- Three times more likely *not* to be linked to care within 90 days
- Twice as likely to be lost to follow-up
- Half as likely to be on anti-retroviral therapy.
- Two to three times more likely to exhibit non-adherence to anti-retroviral therapy.
- Two to four times less likely to achieve viral suppression when prescribed anti-retroviral therapy.

Siemieniuk et al, 2010, 2013; Kalokhe, et al, 2012; Lesserman et al., 2008; Mugavero et al., 2009 Matchinger et al., 2012

Trauma and IPV Can Impact Access to Services

- **Trauma can reduce access to services**
  - Avoidance of trauma reminders; Reluctance to reach out when trust has been betrayed; Retraumatization in service settings; misperception of trauma responses and coping strategies
- **Coercive control, discrimination & lack of cultural attunement can reduce access to services**
- **Without a trauma-informed approach, services can be retraumatizing.** Without an understanding of ongoing risk, services may be unsafe. Without attending to culture, services will not be relevant or accessible. Without a social justice framework, abuse and violence are likely to continue
- **Responding in culturally resonant, trauma-informed ways can help to counteract these effects**

Helpseeking Among LGBTQ Survivors

- Less likely to seek help from law enforcement and mainstream providers and more likely to rely on informal social support and LGBTQ-focused programs.
- Differences among LGBTQ subgroups. Trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services.
- For LGBTQ people of color, stigma, economic constraints, and the absence of community outreach are barriers to services.
- Sanctuary Harm: Services not rooted in an understanding intersecting oppressions LGBQT* survivors face may do more harm than good.

Milller et al., 2017

Findings: Sanctuary Harm and Transformative Justice

- Services not rooted in an understanding intersecting oppressions LGBQT* survivors face may do more harm than good.
- **Kind of harm done by those in a social service system designed to help has been referred to as *sanctuary harm*, and is antithetical to trauma-informed practice.**
- Despite awareness of impact of sanctuary harm on people who experience multiple forms of oppression and unique needs of LGBQT* survivors, limited TI approaches tailored to LGBQT*.

Milller et al., 2017

Understanding the Impact of Trauma

Implications for an IPV- and Trauma-Informed Approach

How is an IPV/Trauma Framework Helpful?

- **Normalizes human responses to trauma**
  - Injury model; Symptoms as survival strategies
- **Allows us to respond in more empathic ways**
  - Acknowledges importance & challenges of connection
  - Restores dignity & respect; Ensures choice; Optimizes control
  - Rehumanizes experience of dehumanization
- **Offers a more holistic approach**
- **Fosters understanding of our own responses** and their potential impact
- **Recognizes the role of culture, social context & coercive control** as well as **sources of strength, resilience and community**

Emergence of Trauma Theory:

Reframing Symptoms from a Trauma Perspective

- **1980's PTSD**
  - Injury model, Symptom constellations
  - Rape Trauma Syndrome, Combat trauma, BWS
- **1990's Complex Trauma and DID**
  - Adult survivors of childhood trauma/ACE study
  - Borderline reframe
  - Developmental lens; multidimensional approach
- **2000's Neuroscience Research**
  - Circuits & networks
  - Gene X environment interactions, neuroplasticity
  - Network analysis, RDoC, Machine learning, GWAS

Herman 1994, 2009, Bloom 1997, van Der Kolk and Courtois 2005, Courtois 2009, Ford 2009, Warshaw 2005

Neurobiology of Trauma & Development: Insights from Neuroscience Research

NY Times

Understanding the Traumatic Effects of Abuse

Why a Developmental Framework Is Important

- **Our brains grow in relation to our experience**
  - Experience stimulates neural circuitry. Those consistently stimulated are strengthened
- **The nature and quality of those experiences help to shape our development**
  - Fine tunes brain architecture.
- **Brain development involves complex interactions between genes & environment over time**
  - Connections develop through attunement. Learning brain vs. survival brain

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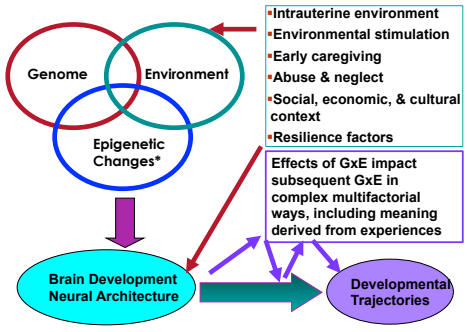
CIVITAS, Harvard Center on the Developing Child

Epigenetics: Trauma, Development & Nature-Nurture Interplay



*Alterations in gene expression

O' Connell et. al. NAS 2009; Kendler 2017

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Epigenetics & Health Disparities Among Native Americans Who Have Experienced ACEs*

Epigenetic Modifications

- ↑ DNA methylation of endocrine regulation genes
- ↑ Methylation of serotonergic genes
- ↓ DNA methylation of inflammatory genes

Health Disparities

- ↑ Rate of psychiatric disorders: PTSD, depression, anxiety, drug & alcohol dependence
- ↑ Rate of suicide
- ↑ Rates of cardiovascular disease, diabetes, and obesity
- ↓ Life expectancy

*ACEs including childhood abuse & neglect, witnessing violence racism and historical loss. Brockie et. al. 2013: The mediating relationship of epigenetics on the risk for health disparities in Native Americans with childhood adversity.

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Early Experience & Brain Development: Mirror Neurons, Empathy & Attunement

- **We develop neural connections through attunement**
- **Empathy & attunement are hardwired**
- **We learn by watching, imitating & matching**
  - Mirror neurons, begin working at birth.
  - They are involved when a child observes an action and then practices performing it.
- **We learn by attuning to others' responses to us**
  - Sense of being seen and known; sense of self; How we are treated affects how we feel about ourselves & other people
- **Learning brain vs. survival brain**

Banissy & Ward 2007; Hunter et. al. 2013

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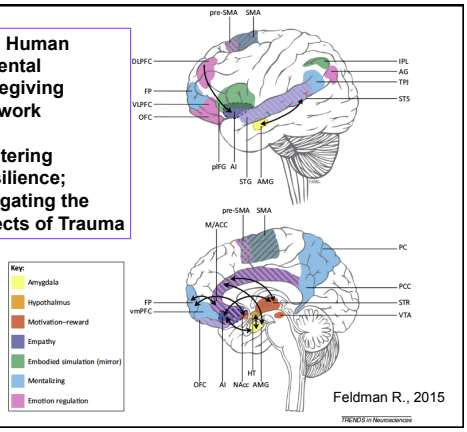
The Human Parental Caregiving Network

Fostering Resilience; Mitigating the Effects of Trauma



Feldman R., 2015

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Countering the Effects of Trauma: Importance of Early Attachment Relationships

- **Model for future relationships & trust**
- **Important source of resilience & ability to manage stress**
- **Template for developing self-regulating, integrative & empathic capacities**
- **Active throughout life**

Van Horn, 2007 for DVMHPI, Lanius et. al., 2006, McLewin & Muller 2006, Shonkoff 2011

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Stress & Trauma in the Context of Attachment

- **Positive stress**
  - Entry to school or child care, managing frustration, routine medical care, riding a bike
- **Tolerable stress**
  - Adverse experiences that occur for brief periods, such as a frightening accident
- **Toxic or Traumatic stress**
  - Stressful events that are chronic & uncontrollable; unrelieved activation of body's stress response system in absence of protective adult support.
- **Complex Trauma**

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National Scientific Council on the Developing Child (2005), Courtois et. al. 2009

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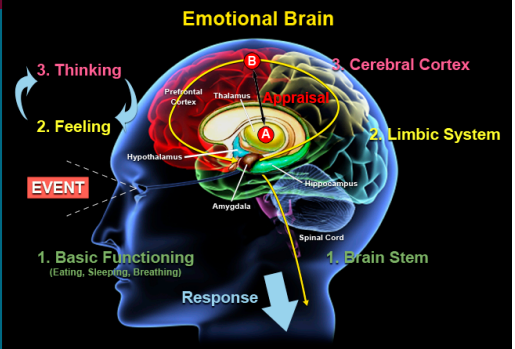
How does this translate physiologically?

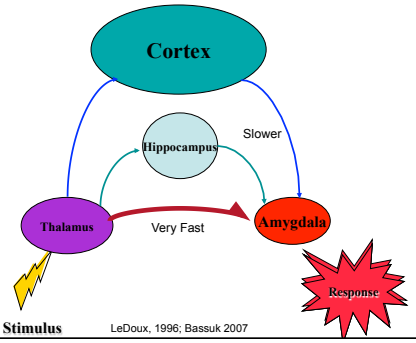
Impact of Trauma on the Brain

How Does Trauma Affect the Brain?



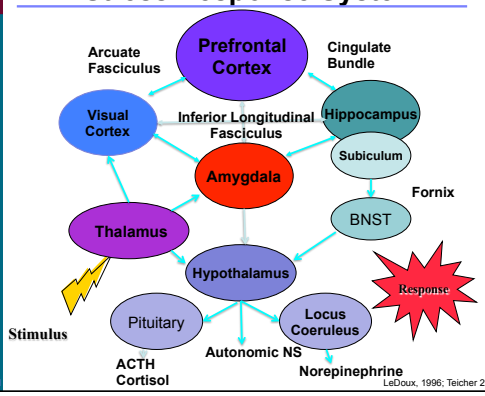
Traumatic Stress Response

Sensitized Nervous System: Under-modulation of Fear Pathways



LeDoux, 1996; Bassuk 2007

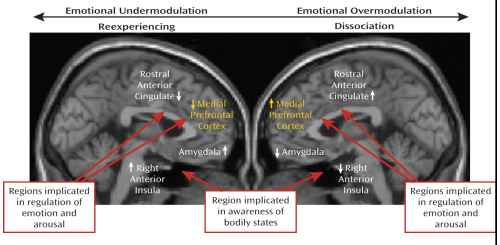
Stress Response System



LeDoux, 1996; Teicher 2014

Emotion Modulation in PTSD:

Clinical & Neurobiological Evidence for a Dissociative Subtype: Cortical Inhibition of Fear Pathways



Lanius et. al. 2010

Thinking about the Neurobiology of Relapse Triggers in the Context of DV

Relapse triggered by exposure to:

- **Addictive/rewarding drugs**
  - Mesolimbic dopaminergic "incentive salience circuitry" and by glutamatergic circuits projecting to the nucleus accumbens from the frontal cortex.
- **Conditioned cues from the environment**
  - Glutamate circuits, originating in frontal cortex, insula, hippocampus and amygdala projecting to mesolimbic incentive salience circuitry.
- **Stressful experiences**
  - Brain stress circuits beyond the hypothalamic-pituitary-adrenal axis at the core of the endocrine stress system. One uses norepinephrine as its neurotransmitter; the other uses corticotrophin-releasing factor (CRF) as its neurotransmitter.

ASAM Definition of Addiction (Hajela et al 2011)

Neurobiological Effects of Trauma: Impact on Health & Mental Health

- **Profound and persistent alterations in physiologic reactivity and stress hormone secretion:**
  - ✓ **Arousal:** Noradrenergic dysregulation, RAS, locus coeruleus: Hyperarousal and threat perception
  - ✓ **Hormonal systems:** Enhanced reactivity and negative feedback inhibition of HPA axis; Increased vulnerability to stress-related illness, allostatic load
  - ✓ **Immune system:** Inflammatory cytokines, telomere shortening
  - ✓ **Memory, learning and emotions:** Hippocampus & Amygdala, mPFC
  - ✓ **Dissociation:** Cortical inhibition of limbic system
  - ✓ **Mood:** Serotonergic activity
  - ✓ **Pain:** Endorphins
  - ✓ **Gene Expression & Neurostructural Changes:** Pathways, synapses, micro-architecture, dendritic density.
- **Alterations in social, cognitive & affective circuits**

Van der Kolk 96, DeBellis et. al., 1999, Perry 2001, Yehuda 2006, Lanius et. al., 2006, Bremner 2006, Gunnar 2007, Southwick 2007, Lanius et. al. 2011

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Complex Trauma: How this can affect us as Adults

- **Managing emotions: Affect dysregulation**
  - Capacity to manage internal states in ways that do not create other difficulties; Avoidance of trauma reminders; Ongoing fear
- **Trusting and valuing oneself & one's community**
  - Feelings of worthiness, right to protect self from harm
  - Center of gravity, collective impact, social fabric, isolation
- **Trusting other people & systems**
  - Harder to reach out for and respond to help; interpersonal challenges; trust that CAN protect from harm..
- **Cognitive & integrative capacities**
  - Solve problems, exercise judgment, take initiative, plan; Working memory, mental flexibility, self-control
  - Accuracy of attributions; Emotional awareness, reflection, social emotional processing, being present

Teicher et al., 2014; Harris, 2001; Saakvitne et al., 2000; Lanius et al., 2011; NDVTMH 2013

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Resilience & Protective Factors

- **Resilience:** Capacity for successful adaptation despite challenging or threatening circumstances
  - Facing fears/active coping; optimism/positive emotions; cognitive reappraisal, positive framing/acceptance; Social competence/social support; Purpose in life, moral compass, meaning, spirituality
- **Protective factors:** Promote resilience in those at risk.
  - Response of caregivers and other caring adults: **Secure attachment can be most important source of resilience & ability to manage stress**
  - Social support, social fabric, community, spirituality, traditions, epigenetic resonance
  - Individual factors such as capacities and talents; specific genotypes
  - Ability to positively engage others
  - Hormones, neuropeptides, neurotransmitters, haplotypes, neural circuitry, epigenetic and transcriptional factors
  - **Food, economic, housing security, safety, & resources**

Feder et al, 2009; McLewin & Muller 2006; Waller 2001; Bell 2006

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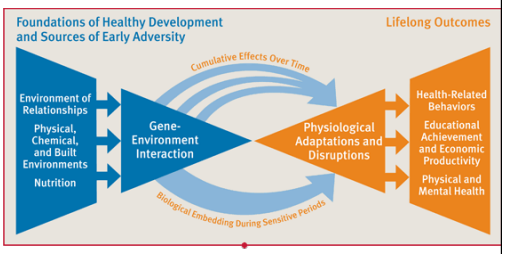
HOW EARLY EXPERIENCES GET INTO THE BODY: A Biodevelopmental Framework Multiple Opportunities for Intervention



Think about sources of ongoing risk

Think about sources resilience and support

Harvard Center for the Developing Child

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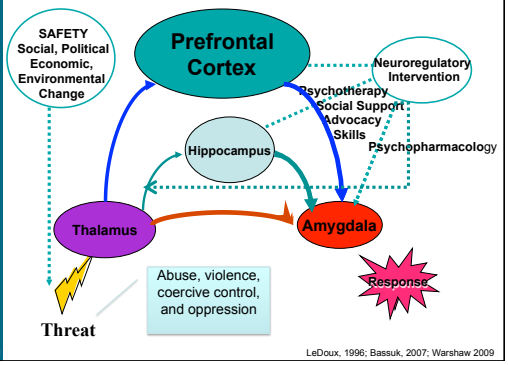
How Interventions Help



LeDoux, 1996; Bassuk, 2007; Warshaw 2009

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Trauma in the Context of DV & Ongoing Sources of Danger

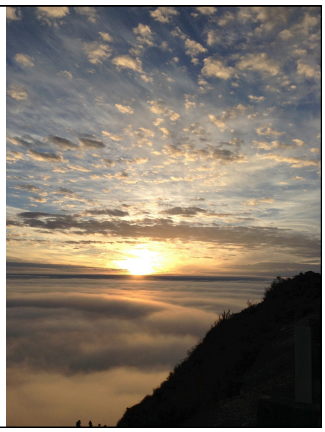
- **PTSD**
  - Trauma is not "post"
  - Appropriate response to ongoing danger
  - "Overreaction" to minor stimuli versus acute social awareness
- **Other Ongoing Trauma**
  - Cultural, historical, political, environmental, insidious

Warshaw 2009

©NCDVTMH

Implications for an IPV- and Trauma-Informed Approach

Once we understand the impact of trauma, oppression and IPV, then a culturally resonant, IPV- and trauma-informed approach becomes a logical next step



How Does Understanding Trauma & IPV Improve Clinical Services?

- Understand role of trauma and IPV in development of health, MH and substance use conditions
- Create safe opportunities to discuss
- Understand people's responses in context
- Respond in more helpful & empathic ways
- Offer more effective interventions
- Understand our own responses and their potential impact & need for organizational support
- Recognize role of social context & ongoing risk

What do we Mean by a Trauma-Informed Approach?

- **Recognize the pervasiveness & impact of trauma**
  - On survivors, on staff, on organizations, on communities
- **Minimize retraumatization**
  - **Counteract the experience of abuse and oppression:** Relational, cultural, environmental & clinical aspects
- **Facilitate healing, resilience & well-being**
  - **Mitigate the effects of abuse**: Culturally resonant, DV/ Trauma-informed and –specific approaches & treatment
- **Attend to impact on providers & organizations**
- **Work to address social conditions that perpetuate abuse, trauma, discrimination and disparities**

Saakvitne et. al. 2000, Harris & Fallot 2001, NCDVTMH 2009

Principles of a Trauma-Informed Approach

- **Physical and Emotional Safety**
- **Relationship and Connection**
  - Trustworthiness, Transparency, Collaboration, Mutuality
- **Empowerment and Choice**
- **Resilience and Hope**
- **Cultural, Historical, Gender and Community Context**
- **Human Rights/Social Justice/Transformative Justice**

DV- and Trauma-Informed Services

How Does this Translate into Practice?

Creating Culture- IPV- and Trauma-Informed Services & Organizations: Key Domains

Practice Domains

- Physical, Sensory & Relational Environment
- Intake and Assessment Process
- Clinical Services

Organization or System Domains

- Organizational Commitment & Infrastructure
- Staff Training and Supports
- Collaboration & Referral Relationships
- Performance Improvement, Feedback & Evaluation

NCDVTMH-ACDVTI, 2014

Responding to Trauma and IPV in Health Care Settings

- Create a safe, welcoming environment
- Attend to privacy and confidentiality
- Provide information and create opportunities to discuss
- Address immediate safety needs
- Incorporate into health, MH/SU assessment & social history
- Provide initial counseling
- Incorporate into treatment/planning
- Document with IPV in mind; Offer referrals & follow-up

Safe, Secure, Welcoming Environment

Multiple Perspectives on Safety

- **Mental Health Context**
  - Self-harm; Harm to others
- **Trauma Context**
  - Retraumatization; Potentially risky coping strategies
- **Substance Use Context**
  - Increased risks; Medical effects
- **Domestic Violence Context**
  - Ongoing danger & coercion from partner; Revictimization by other people and systems

Warshaw, et. al. 2009

Think about Your Physical & Sensory Environment:

Physical & Sensory Environment

- **Attend to Physical Safety**
  - Parking lots, common areas, entrance/exits - well-lit, security personnel building; clear access to door in exam rooms; easy exit if desired; Work place safety policies for patients and staff
- **Attend to Sensory Impact**
  - Sights, sounds, colors, smells, lighting and brightness
  - Noise, chaos, level of sensory stimulation, loudspeakers,
  - Clear signage; non-traumatizing information; culturally resonant artwork (and food); gender-inclusive/gender-responsive
- **Offer Options and Choices**
  - Do people have a choice about being in a public waiting area vs. quieter, more private place? If a situation becomes overwhelming, are there things a person can do or someone with whom they can talk to make it feel safer and more comfortable for them? Are there places staff can go when they need a quiet space?

Relational Environment

When trauma occurs in a relationship, the quality of the relationships we create is key……

Relational Environment

- **Collaboration, Mutuality, Choice & Control:** Counters abuse of power through shared information, shared power, choice & control
- **Trustworthiness & Respect:** Counters secrecy and betrayal through transparency, consistency and trustworthiness
  - Being clear about expectations
  - Maintaining respectful interpersonal boundaries; no Jekyll-Hyde behavior
  - Creating a safe atmosphere to discuss misunderstandings
  - Recognizing that what feels safe may be unique to each person

DV- and Trauma-Informed Assessment Process

Screening and Assessment: Issues and Controversies

- **Intimate Partner Violence**
  - Screening vs. informational conversations and opportunities to discuss
- **Lifetime Trauma**
  - Universal Screening vs. Universal approach?
  - Task-centered vs. Relationship-centered?

Teram et al 1999; Havig 2008, www.csacliniclansugide.net

Clinical Assessments: What Would A TI Approach Involve?

Genuine interest and openness
- Create safe atmosphere for patients to discuss what is important to them; Remember disclosure is a choice
- Relate with empathy, validation, & respect

Attention to imbalances of power
- Create opportunity to participate in give-and-take relationship without risk of judgment or retaliation
- Share concerns without imposing own point of view

Consideration of Potential Impact
- May not perceive situation as abusive; May not have memory of past abuse
- May trigger painful memories; Detailed accounts may be retraumatizing
- Talking may provide relief and enhance sense of control

Awareness of our own responses
- Ability to tolerate fear and uncertainty

Miller et al., 2016; Warshaw, et. al. 2009

Work with Survivors Assess Their Situations: Key Elements to Discuss

- **Routine inquiry** about relationships and IPV
- **Safety** in clinical setting & risk for future harm; other threats to safety (suicide, homicide, partner's substance use)
- **History and pattern** of abuse
  - Including ways abuser uses their partner's health, mental health and substance use as a way to undermine or control them
- **Impact of IPV**: On health, MH, substance use and on their children; impact on how they think and feel about themselves; how they view their situation.
- **Other trauma**: Are there other things that have happened to you that may be affecting how you are feeling now?
- **Strengths, coping strategies, barriers, concerns, priorities & goals**
- **Access to advocacy, support and resources**

Creating a Safe Environment: Establishing Physical Safety

- **Ensure privacy and physical safety**
- ***Never ask:***
  - In the presence of a someone not identified as safe
  - During couple's therapy; in the presence of children
  - A partner or family member for corroboration
- **Be mindful about asking:**
  - An abusive partner for collateral information
- **Use professional translators**
- **Discuss limits of confidentiality**

2.83

Attend to IPV-Specific Concerns

- **Recognize that** perpetrators may look psychologically healthier than the partner they've been abusing for years.
- **Be wary of** having abusers provide collateral information; Ask about advance directives, control of finances, guardianship
- **Do not focus on** helping a person who is being victimized understand why they unconsciously "chose" to be abused.
- **Incorporate questions about** health, reproductive, mental health and substance use coercion into safety planning
- **Ask about** suicidality in the context of trauma, abandonment, resistance and perpetrator threats
- **Anticipate trauma triggers**; distinguish from necessary vigilance
- **Ensure** choice and control re: medication
- **Consider** impact of trauma & DV including TBI on ability to process information
- **Facilitate access** to community DV resources

Warshaw et. al. 2009

Trauma-Informed Trauma History: To Ask or Not To Ask?

- **When to Ask:** When you have established rapport and trust, feel comfortable discussing, can provide environment that feels safe, have sufficient time, and have access to referrals
- **Task-Centered Inquiry:** Opportunity for person to share information immediately relevant to treatment (touch sensitivity) without having to disclose in context of new provider and absence of rapport.
  - **Initial questions**: Is there anything about your past experiences that makes this exam particularly difficult for you? What can I do to make it more comfortable for you? Are there other things that have happened to you that may be affecting how you are feeling now?
- **Relationship-Centered:** Initiated by patient after trusting relationship established, leading to enhanced understanding of patient needs, greater expectations for positive and supportive response

2.85

Teram et al 1999; Havig 2008, www.csacliniclansugide.net

Trauma-Informed Assessment: Providing Information; Normalizing Experiences

- **Talk with patients about the effects of DV/SA and other trauma in ways that help to normalize and destigmatize their experiences and offer information, tools, resources & hope.**
  - Common physical and emotional effects of trauma and DV and ways these responses can interfere with accessing safety, processing information or remembering details
  - Ways that trauma can affect our ability to trust and manage feelings and affect the ways we feel about ourselves, other people and the world

Warshaw et. al. 2009

Emotional Safety Planning: Traumatic Effects of Abuse

- **Physical, psychological, and emotional abuse can affect our mental and emotional well-being**
  - For example, a person may feel afraid all the time, or may find that loud noises startle them; they may have nightmares or trouble sleeping or they may have sudden, upsetting memories of abusive incidents that interfere with things they want to do.
- **Being aware of your feelings can help you anticipate situations which are likely to evoke a trauma response** (i.e. things that make you feel afraid or upset, or cause nightmares) and make decisions about how to handle them.
  - Let's think about what might be helpful. What are some of the things that help you feel calm and grounded?

Markham 2009, ASRI

Trauma-Informed Intake & Assessment: Providing Information; Normalizing Experiences

- **Talk with survivors about …..**
  - The ways abusers use mental health and substance use issues to control their partners
  - Sources of strength and resilience; Hopes, dreams, beliefs, priorities, strategies and goals

Ask About the Children

- **Perception of impact on children & concerns**
- **Efforts to protect and care for children**
- **Observations of attachment and parenting**

2.89

Ask About Mental Health & Substance Use Coercion

- Has your partner ever tried to control your medication, or access to treatment? Has he/she actively undermined your sobriety/ recovery?
- Has your partner deliberately done things to make you feel like you are "going crazy" or "losing your mind?"
- Has your partner ever forced you to use substances, take an overdose, or kept you from routines that are healthy for you?
- Has your partner blamed you for his/her abusive behavior by saying you' re the one who is "crazy" or an "addict?"
- Has your partner used your substance use or mental health condition as a way to discredit you with other people?
- Has your partner threatened to take your children away because you are receiving substance use or mental health treatment?

3.90

Warshaw 2012

Ask Mental Health Coercion as Part of an IPV Assessment:

- If a person does indicate that they are being abused by an intimate partner, also ask about how the abuse has affected their mental health
- Many people say that their abusive partners do or say things to make them feel like they might be 'going crazy,' interfere with their treatment or medication, or do things to undermine them with their friends and family or with other people they might turn to for help. Have you ever experienced anything like that?"

Warshaw and Tinnon 2017

Ask as Part of a Mental Health History

- Ask about the **relationship of mental health symptoms to current abuse or previous trauma, including mental health coercion**
- Ask **how their partner responds when they are symptomatic**.
- When discussing **medication & treatment planning**, ask about how they think their partner might respond

Warshaw and Tinnon 2017

Offer Perspective

- **Remember that** a partner who is abusive may try to find other people to agree that your mental health needs give him/her a right to control or abuse you. This is not so.
- **Even if you have** had many hospitalizations, or used medication for years, you have the same right to safety and dignity as anyone else.
- **It might be helpful to think about** which people in your life agree that you have a right to safety and dignity and who you can call on for support.

Markham 2011

Discuss Coping Strategies: Counteract Abuser Control

- **Survivors may find it helpful to talk about how the abuse is affecting how they think and feel.**
  - Are there things you've noticed about how your partner's behavior is affecting how you think or feel?
  - What are some of the things you do to help you cope? What have you found to be most helpful?
  - How are your responses to the abuse helping you to stay safe, both physically and emotionally?
  - Are there ever times when you find your responses or coping strategies are getting in the way of staying safe or creating additional difficulties for you? What have you noticed? What have you been thinking about this? Are there things that you think might be helpful to you?

Discuss Trauma Triggers; Distinguish from Necessary Vigilance; Create Emotional Safety

- **Physical, psychological, and emotional abuse can affect our emotional well-being**
  - You might feel continually afraid, loud noises startle you, you may have nightmares or trouble sleeping, you may have sudden, upsetting memories of abusive incidents that interfere with activities.
- **Being aware of your feelings can help you to anticipate situations which are likely to trigger a trauma response and to make decisions about how to handle them.**
  - Let's think about what might be helpful. What are some of the things that help you feel calmer and more like yourself?

Markham 2009, ASRI

Strategize About Ways to Safely Access Treatment & Services

Discuss:

- Safe times and places to make or receive calls, to send information, and to schedule appointments
- EHR privacy concerns and protection of sensitive information
- Options for managing medication safely
- Safe strategies for keeping appointments
- Any legal documents giving an abusive partner control
- Referrals to DV advocacy programs

Warshaw and Tinnon 2017

Asking About Substance Use Coercion

Ask About Substance Use Coercion as Part of a DV Assessment

- "Sometimes, people who are being hurt by someone in their life or who have been hurt in the past use alcohol or other drugs to help them cope. This includes over-the counter, prescription and other kinds of drugs and substances that may or may not be legally available.
- Many people report their partner makes them use alcohol or other drugs, makes it hard for them to stop or prevents them from stopping, uses their alcohol or other drug use as a way to control them, or does other hurtful things related to their alcohol or other drug use. Does this sound like anything you might be experiencing?"

Warshaw and Tinnon 2017

Ask as Part of a Substance Use History

- Have you ever felt like you **ought to cut down** on your drinking or drug use or **tried to cut down** on your drinking or drug use? Has your **partner ever tried to stop you from cutting down** on your drinking or drug use?
- Have you ever been **annoyed by someone criticizing** your drinking or drug use? Have you ever been **made to feel afraid by someone's criticizing** your drinking or drug use? Has your partner used your drinking or drug use as a way to threaten you?
- Have you ever felt **guilty** about your drinking or drug use? Have you ever felt **coerced** into drinking or using drugs or engaging in illegal activities or other behaviors you weren't okay with or that compromised your integrity, **and then felt guilty** about it?
- Have you ever had an **eye-opener** first thing in the morning because drinking or using drugs **felt like the only way you could survive** or get through the day, steady your nerves, or relieve a hangover? Have you had an **eye-opener** first thing in the morning **because you were forced** to drink or use drugs right away?

Warshaw 2009; Warshaw & Tinnon 2017

Substance Use in Context

Survivor's assessment of:

- Relationship of substance use to current and past abuse
- Role of abusive partner in maintaining substance use & how impacted
- Survival strategies
- Function substance abuse serves (how it helps)
- Impact and other risks (how it hurts)
- Attempts to stop, goals, barriers, options and strategies

2.100

Offer Perspective

- Your partner might find other people to agree that your substance use gives them a right to control or abuse you. Undermining your credibility with other people makes it difficult for you to get support, be believed, and trust your own perceptions.
- It is never your fault when someone harms you if you are drinking or using – regardless of what your partner or society tells you. Your use does not justify violence against you on any level. You deserve to be treated with dignity and respect.
- You mentioned that your partner regularly tries to get you to use when you don't want to or to use more than you're comfortable with. Is there someone you could call if this is happening to support you or offer some perspective?

Warshaw & Tinnon 2017

Discuss Coping Strategies and Emotional Safety

- Are there things you've noticed about how your partner's behavior is affecting how you think or feel? Do you find that you don't have the energy to fight them about these issues?
- What are some of the ways you cope? What do you find works the best?
- Have you thought about ways that you can protect yourself while you're still in the relationship? We can talk about some ways to reduce the harm. Are you familiar with medications that reverse opioid overdose?
- Do you find that not using is harder when your partner pressures you to use? Do you worry about what will happen if you refuse to use? Do you want to brainstorm some strategies that might increase your safety and reduce harm?

Warshaw & Tinnon 2017

Strategize Safe Ways to Access Treatment and Services

- Discuss whether there are there safe times or places to receive phone calls, bills, statements
- Discuss safe strategies for keeping appointments
- Discuss options for managing medication safely. This may be particularly relevant if the person is receiving MAT
- Discuss whether keeping regular appointments (e.g. methadone treatment) raises concerns about being stalked. Discuss ways to stagger appointment times or try switching to another form of treatment
- Discuss any legal documents that enable the abuser to have control over the person's care

Warshaw & Tinnon 2017

Strategize Safe Ways to Access Treatment and Services

- Discuss privacy concerns related to documentation and electronic health records.
- Discuss referrals to IPV professionals.
- Discuss referrals to substance use professionals who are sensitive to both trauma and IPV and are culturally attuned and gender-responsive. This is especially helpful for women, genderqueer, and transgender individuals who often struggle to find affirming care
- Ask about what childcare supports a survivor might need to be able to access treatment, particularly if residential options are being considered.

Warshaw & Tinnon 2017

Analyzing Risks: Staying vs. Leaving

Batterer-Generated	Life-Generated
Physical Risks	Financial
Psychological Risks	Home location
Children	Phys. & Mental Health
Financial	Institution Response
Family & Friends	Discrimination
Relationship (Loss)	Batterer manipulation
Legal (arrest, residency status)	Perception of Resources

2.105

Davies, Lyon, Monte-Catania, 1998

Trauma-Informed Support for Medical Exams and Procedures

Universal Precautions: Anticipate and Prepare for Potential Trauma Triggers

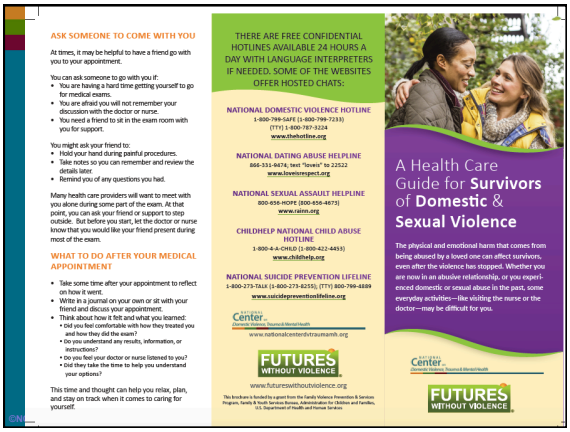
- **Medical Procedures**
  - Pap smear or pelvic exam, L&D, Mammograms, Breastfeeding, Ultrasound gel
  - Catheterization, Intubation, IV insertion
  - Laryngoscopy/endoscopy/colonoscopy/MRI/CT, Oral exam
  - Surgery, Anesthesia, Recovery room
- **Chaotic sensory environment; Gender-related concerns**
- **Relational triggers**
  - Closed room, Having to disrobe, Masked and gowned providers, Being touched, False reassurances, Lying down, Lying still

Wagner 2009; www.csacliniciansguide.net

Trauma-Informed Medical Examinations

- **Always ask** for consent. Ensure continued consent at each step.
- **Explain** what will be done, how it will be done, and why it is necessary
- **Ask whether the person would like someone with them**
- **Do not assume** that any procedure or examination is routine.
- **Observe body language**. Ask ''Are you comfortable with this?'' or ''Is it OK if I continue with the exam?''.
- **Avoid** false **reassurance.** Offer specific suggestions on how to relax if needed. Discuss in advance. Write things down
- **If the person is triggered**, speak in calm voice & let them know where they are and that they are in a safe place. Encourage them to look at you and focus and to take breaths
- **Use similar precautions if examining a person's children**

https://healthasahumanright.wordpress.com; Aaron et al. 2013; Cole et al. 2009



ASK SOMEONE TO COME WITH YOU

At times, it may be helpful to have a friend go with you to your appointment.

You can ask someone to go with you if:
- You are having a hard time getting yourself to go for medical exams.
- You are afraid you will not remember your discussion with the doctor or nurse.
- You need a friend to sit in the exam room with you for support.

You might ask your friend to:
- Hold your hand during painful procedures.
- Take notes so you can remember and review the details later.
- Remind you of any questions you had.

Many health care providers will want to meet with you alone during some part of the exam. At that point, you can ask your friend or support to step outside. But before you start, let the doctor or nurse know that you would like your friend present during most of the exam.

WHAT TO DO AFTER YOUR MEDICAL APPOINTMENT

- Take some time after your appointment to reflect on how it went.
- Write in a journal on your own or sit with your friend and discuss your appointment.
- Think about how it felt and what you learned:
  - Did you feel comfortable with how they treated you and how they did the exam?
  - Do you understand any results, information, or instructions?
  - Do you feel your doctor or nurse listened to you?
  - Did they take the time to help you understand your options?

This time and thought can help you relax, plan, and stay on track when it comes to caring for yourself.

THERE ARE FREE CONFIDENTIAL HOTLINES AVAILABLE 24 HOURS A DAY WITH LANGUAGE INTERPRETERS IF NEEDED. SOME OF THE WEBSITES OFFER HOSTED CHATS:

NATIONAL DOMESTIC VIOLENCE HOTLINE
1-800-799-SAFE (1-800-799-7233)
(TTY) 1-800-787-3224
www.thehotline.org

NATIONAL DATING ABUSE HELPLINE
866-331-9474; text "loveis" to 22522
www.loveisrespect.org

NATIONAL SEXUAL ASSAULT HELPLINE
800-656-HOPE (800-656-4673)
www.rainn.org

CHILDHELP NATIONAL CHILD ABUSE HOTLINE
1-800-4-A-CHILD (1-800-422-4453)
www.childhelp.org

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (1-800-273-8255); (TTY) 800-799-4889
www.suicidepreventionlifeline.org

National Center on Domestic Violence, Trauma & Mental Health
www.nationalcenterdvtraumamh.org

FUTURES WITHOUT VIOLENCE
www.futureswithoutviolence.org

This brochure is funded by a grant from the Family Violence Prevention & Services Program, Family & Youth Services Bureau, Administration for Children and Families, U.S. Department of Health and Human Services

A Health Care Guide for **Survivors** of **Domestic** & **Sexual Violence**

The physical and emotional harm that comes from being abused by a loved one can affect survivors, even after the violence has stopped. Whether you are now in an abusive relationship, or you experienced domestic or sexual abuse in the past, some everyday activities—like visiting the nurse or the doctor—may be difficult for you.

National Center on Domestic Violence, Trauma & Mental Health

FUTURES WITHOUT VIOLENCE

If you avoid visiting the nurse, doctor, or dentist, you're not alone. Many survivors of abuse find that seeing a healthcare provider can make them feel anxious or uncomfortable.

Going to the clinic can also be hard because some health care providers are not always sensitive to the ways that trauma can impact health or they seem rushed, making it hard to connect. There are steps you can take to make health visits easier and be more involved in your healthcare.

WHY IS GOING TO MY DOCTOR OR NURSE SO HARD FOR ME?

Studies have shown that experiencing trauma and violence can lead to many health problems. The stress of abuse takes a toll on the body and on a person's well-being, and can lead to ongoing health issues.

Experiencing violence by a loved one can affect how we feel and may be traumatic. We may use a variety of coping strategies to survive: we may distance ourselves, minimize the experience, avoid thinking about it, and even sometimes deny to ourselves that what we are experiencing is painful. These ways of coping sometimes make survival easier. However, they can also become a routine way of thinking, or dealing with hard situations, even when we no longer need them.

Seeing a doctor or nurse means you're paying attention to what's going on in your body. At the same time, it might be hard for you to focus on your body for many reasons. For example, to cope with stress or anxiety, you may distance yourself, or "go away in your head." This is what some call "dissociating" and it can make it hard to feel what's going on in your body. This is a clever tool our minds use to give us a break from trauma. It allows us to function and keep going, but it can also get in our way. The problem comes if we dissociate when we need to be present to take in and process information, or say what we need. A health visit can also bring up responses such as fear, or difficult memories of the abuse that make us dissociate when we may actually want to stay present.

Waiting rooms can be stressful and hectic. Tests and exams can leave us feeling vulnerable or remind us of the violence that we've experienced in the past. Language or other cultural differences between you and your provider may also complicate your ability to understand or connect with each other. All of these things can get in the way of a health visit going the way that we want it to.

WHAT CAN I DO TO MAKE MY NURSE/DOCTOR VISITS EASIER?

Tell them about your concerns

You can tell your nurse or doctor about concerns that you have, such as that exams sometimes make you feel nervous, and if there are things that would make you feel more at ease. If you feel comfortable, you can also let them know that you are a survivor of violence. Knowing about the abuse may help your provider meet your health care needs. You can share how you think the violence has affected your health. For example, you may want to discuss past injuries, unprescribed medications, possible sexually transmitted infections (STIs), unplanned pregnancies, and ways in which you might have coped through use of drugs or alcohol. Your doctor or nurse can then help you consider ways to address these concerns.

Trust your instincts during this discussion. Not every doctor or nurse will support or understand your needs. Ideally the relationship between you and your doctor or nurse should feel supportive and open enough for you to feel comfortable talking with them about what is important to you. If you feel dismissed or judged by the nurse or doctor, they may not be the right one for you. Find a doctor or nurse who listens, is sensitive to your needs, and supports you.

Take charge of the visit

If you're worried that your visit may trigger fear, bad memories, or cause you to "space out" or dissociate, consider making a plan with your health care provider ahead of time. Making such a plan may increase your sense of control over your appointment and may make it easier for you to feel comfortable and participate in decisions. If you are unsure what to ask for, consider this approach you can share with your doctor or nurse:

The doctor or nurse should take these steps:

BEFORE THE EXAM:

1. Meet with you when you are fully dressed before the physical exam to discuss the reason for the visit and to review the procedure step-by-step.
2. Leave the room to allow you to change clothing for the physical exam.

DURING THE EXAM:

3. Wait for your approval before proceeding with each step. For example, the doctor might say, "Now I'm going to lift your gown and push hard on your abdomen, OK?" You can then indicate whether or not the provider is OK to proceed.
4. If the exam can't be completed, you and the provider can agree to reschedule it and discuss ways in which the procedure might be made easier, if possible.

AFTER THE EXAM:

5. Give you the option of getting dressed again after the exam, before discussing possible next steps with the nurse or doctor.
6. Leave you with written follow-up information. Include diagnoses, medication schedules, and next steps.

Change these steps if needed so that they feel most comfortable for you.

Trauma-Informed Clinical Practice

- **Flexible, individually tailored services that are also responsive to specific types of trauma** (e.g., DV, Trafficking, CSA, transphobic violence, historical trauma, immigrant/ refugee-related trauma, traumatic bereavement, medical trauma, community violence, disaster, combat, etc.)
- **Adequate time**
- **Team approach** to address and coordinate complex needs and concerns; Huddles; Embedded behavioral health providers; Peer support workers; Active patient involvement in team and decision-making
- **Strategies to maintain contact**
- **Access to trauma-specific treatment and holistic, culturally relevant interventions**

Lewis-O'Connor, 2016; Raja, 2015

Documenting the Traumatic Effects of DV

- **Document relationship of symptoms to abuse**
- **Discuss potential to subside** when safe
- **Carefully frame** diagnoses and medication
- **Recognize appropriateness of anger**
- **Describe strengths**, coping strategies, & observations of ability to care for and protect children
- **Describe engagement** in treatment; Make sure treatment plan is acceptable and doable
- **Describe observations** about abuser
- **Be alert to abuser** who seems "healthier" than victim

Markham D 2007, Warshaw 2007

Facilitating Healing and Recovery

Facilitate Healing & Recovery

Healing from interpersonal trauma involves restoring safety, connections, capacities, trust, dignity, respect, meaning & hope and managing dysregulated neurophysiology.

Elements include:

- Physical and emotional safety
- Empowering Information, collaboration & choice
- Building on strengths & resilience
- Enhancing affect regulation and interpersonal skills
- Establishing safe, supportive relationships
- Facilitating reintegration and rebuilding
- Developing or reconnecting with supportive aspects of culture, community & spirituality and engaging meaningful activities.

Herman 1992, Ford & Courtois 2009

For survivors of **ongoing domestic violence**, responding to trauma raises an additional set of concerns, particularly when the **trauma is unremitting** and **symptoms also reflect a response to ongoing danger and** coercive **control.**

Warshaw 2009

How does one heal while still under siege?

Warshaw 2009

Trauma Treatment in the Context of DV

- **Symptom-focused vs. Holistic approach**
  - PTSD treatment targets specific symptoms; Complex trauma treatment addresses multiple domains
- **Past abuse vs. Ongoing risk**
  - Most trauma treatment models focus on past abuse; Few are designed for survivors still under siege whether from DV or oppressive conditions
  - Some evidence-based treatments for PTSD can be harmful in context of complex trauma and/or ongoing abuse
  - Women experiencing DV often excluded from clinical trials
- **Treatment should integrate both DV and trauma concerns**

Warshaw et. al., 2009, 2013

Trauma-Specific Treatment Including Treatment for Survivors of DV

- **PTSD Treatment**
  - Robust evidence base: CBT, PE, EMDR
  - Emerging evidence: Mindfulness-based interventions, Mind-Body therapies, Virtual therapies
- **IPV + PTSD Treatment**
  - 24 RCTs but evidence still limited: Modified CBT, yoga-based therapy; often out of the relationship + HOPE, MBSR, CPT, [DBT & Seeking Safety (adapted)]
- **Complex Trauma Treatment**
  - EBPs for less severe complex trauma (Hybrid)
  - Consensus Phase-Based for Complex trauma: EB modalities embedded in relational, developmental matrix; Begin with safety, stability, relationship
  - Combined trauma & substance abuse treatments; DBT
- **Culturally Specific Responses to Collective Trauma**

Foa et. al. 2005, Warshaw et. al. 2009, 2013, Cloitre et. al. 2011, Courtois & Ford 2009, Serrata, Cook

Treatment Models for Complex Self-Dysregulation: Hybrid Models

- **Affect regulation and interpersonal skills training** prior to introducing exposure techniques
- **Current stressor experiences** and more recent memories serve as vehicles for examining and dealing with interpersonal difficulties and problematic emotions
- **Emphasis on therapeutic attachment** as a vehicle for enhancing survivors' capacities for self-regulation

2.119

Ford et. al. 2005, Courtois and Ford, 2009, 2013, Cloitre 2010

Need for Cross-Sector Collaboration

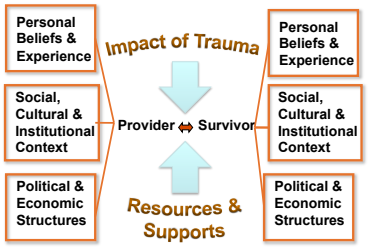
- **Treatment modalities that specifically address IPV**:
  - Integrated Relapse Prevention and Relationship Safety (RPSR) Intervention for Women on Methadone
  - WINGS IPV SBIRT
  - Seeking Safety Adaptations
    - + CTT-BW
    - CCADV Learning Circle
- **Integrated Services Models**
  - OUDs: MAT, TI interventions and services that allow them to continue to care for their children
- **Collaborative Approaches**

Gilbert et. al, 2006, 2016, Myers et. al, 2015; Kubany et. al, 2003, 2004 Collins CCADV

Creating DV- and Trauma-Informed Practices, Training Programs and Institutions

What else is involved?

In a Trauma-Informed Approach, We Are Also Part of the Equation

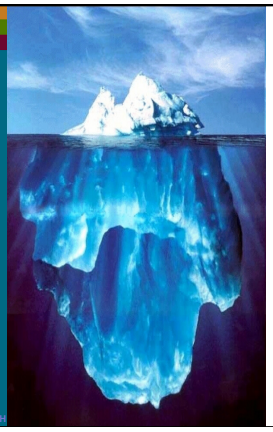


Warshaw 2013

Being Aware of Our Own Responses:

- **Fear** of being overwhelmed or making bad decisions
- **Reluctance** to identify with "victim"
- **Helplessness** & inadequacy if can't "fix" or predict outcomes
- **Frustration** with survivor for not responding to our needs to do a good job
- **Lack of attention** to personal history and vicarious trauma
- **Avoid, dismiss, blame, label, control**

When competence is tied to mastery & control



Thinking about Transference & Countertransference

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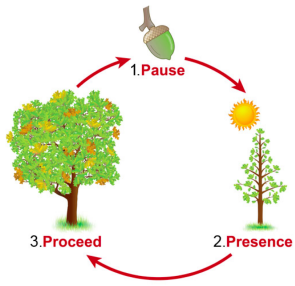
What May Be Below the Surface…

3-Step Mindfulness Practice For Health Care Provider Burnout

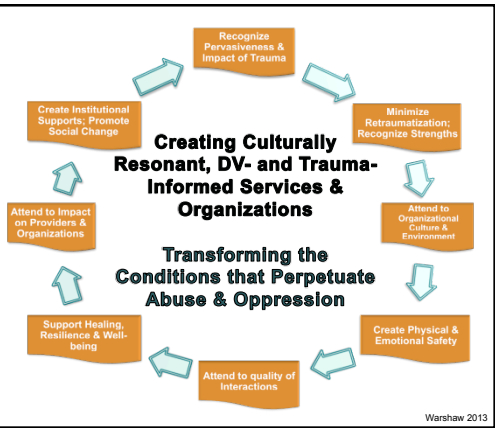


University of Wisconsin Department of Family Medicine
http://www.fammed.wisc.edu/

Organizational Commitment: Ask Yourself

- How does your institution support training and workforce development to help all staff develop the knowledge and skills to work sensitively and effectively with survivors of IPV and other trauma?
- How does your institution support clinicians in dealing with and learning from the feelings that come up for them in working with individuals who have had traumatic experiences?
- What types of training and resources are provided to supervisors on incorporating reflective, IPV- and trauma-informed approaches into their ongoing supervision?
- How does workforce development/staff training address the ways identity, culture, and oppression can affect a person's experiences trauma, access to supports and resources and opportunities for safety and recovery?

Warshaw et al., 2017



Warshaw 2013

Being trauma informed means embodying in our own practices and institutions the world we want to create

Selected NCDVTMH Resources

- **A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors:** http://www.nationalcenterdvtraumamh.org/publications-products/ncdvtmh-review-of-trauma-specific-treatment-in-the-context-of-domestic-violence/
- **Mental Health and Substance Use Coercion Surveys Report** http://www.nationalcenterdvtraumamh.org/2014/09/mental-health-and-substance-use-coercion-surveys-report-now-available/
- **Trauma in the Context of DV** http://www.nationalcenterdvtraumamh.org/2014/10/ncdvtmh-guest-edits-special-issue-of-synergy-in-honor-of-dv-awareness-month/
- **Trauma-Informed Care for Mental Health Professionals:** http://athealth.com/trauma-informed-care-for-mental-health-professionals/
- **Substance Use/Abuse in the Context of DV, Sexual Assault & Trauma** http://www.nationalcenterdvtraumamh.org/publications-products/substance-useabuse-in-the-context-of-domestic-violence-sexual-assault-and-trauma/
- **Relationship Between IPV & Substance Use: Applied Research Paper**
- http://www.nationalcenterdvtraumamh.org/2016/03/new-resource-the-relationship-between-intimate-partner-violence-and-substance-use-an-applied-research-paper/
- **Mental Health Treatment for Survivors of IPV**
- http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2015/10/Mitchell-Chapter-24.pdf
- **Trauma-Informed Approaches for LGBQT* Survivors of Intimate Partner Violence: A Review of Literature and a Set of Practice Observations** *http://bit.ly/2h7r8ov*

Resources

LGBTQ Anti-Violence Organizations

- National Coalition of Anti-Violence Programs – www.avp.org
- Communities United Against Violence – www.cuav.org
- The Northwest Network – www.nwnetwork.org
- Violence Recovery Program at Fenway Health – http://fenwayhealth.org/care/behavioral-health/vrp/
- The Network/La Red – www.tnlr.org
- FORGE (Trans-specific) – www.forgeforward.org
  - Not a direct service organization, but can connect survivors to transgender-responsive anti-abuse services throughout the country.

In addition:

- Many, but not all, rape crisis centers that are good with male survivors are also good with trans, gender non-conforming, and LGB survivors of sexual assault/abuse.
- *Male Survivor.org* and *1 in 6* are responsible national organizations that provide virtual community and connection to all men, including affirmative services for gay and bisexual men.

NATIONAL Center on Domestic Violence, Trauma & Mental Health

Carole Warshaw MD

55 E. Jackson Blvd., Suite 301
Chicago, IL 60604
P: 312-726-7020
TTY: 312-726-4110
www.nationalcenterdvtraumamh.org
cwarshaw@ncdvtmh.org
Twitter: @ncdvtmh
Instagram: @ncdvtmh

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