Making the Connection:
Intimate Partner Violence (IPV) and Public Health

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For more information and program support, contact the National Health Resource Center on Domestic Violence, a project of the Family Violence Prevention Fund:

• Monday-Friday (9-5 PST)
• Toll-free (888) Rx-ABUSE (792-2873)
• TTY: (800) 595-4889
• Online: www.endabuse.org/health

In addition, this PowerPoint presentation may be downloaded from the Family Violence Prevention Fund's website: www.endabuse.org/health
The National Health Resource Center on Domestic Violence provides specialized materials and tools including:

- Consensus Guidelines on Routine Assessment for D.V.
- Pediatric Guidelines on Routine Assessment for D.V.
- Business Case for Domestic Violence
- Multilingual Public Education Materials
- Training Videos
- Multi-disciplinary policies and procedures
- Cultural competency information and materials specific to many communities
- Online e-Journal: *Family Violence Prevention and Health Practice*
- Health Cares About Domestic Violence Day (2nd Wednesday of October annually)

Visit [www.endabuse.org/health](http://www.endabuse.org/health) for more information
<table>
<thead>
<tr>
<th>MENU</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELECT FROM THE TOPICS BELOW</td>
</tr>
</tbody>
</table>

- Overview
- Regional and Local Data
- Medical Cost Burden and Health Care Utilization for IPV
- The Impact of IPV on Women’s Health
- IPV and Behavioral Health
- IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
- IPV and Sexually Transmitted Infections/HIV
- IPV and Perinatal Programs
- IPV, Breastfeeding, and Nutritional Supplement Programs
- IPV and Child and Adolescent Health
- ACE Study: Leading Determinants of Health
- IPV and Injury Prevention
- IPV and Home Visitation
Overview:
Intimate Partner Violence (IPV) as a Public Health Priority
• 1985 – Surgeon General declares DV a leading public health issue
• 1989 – ACOG Technical Bulletin
• 1991 – ANA Position Statement
• 1992 – AMA Diagnostic Guidelines
• 1992 – APHA Position Paper
• 1994 – AAFP Position Paper
• 1998 – AAP Policy Statement
• 1999 – APA Resolution
• 2000 – AANP Statement and Resolutions
• 2002 – WHO declares violence a worldwide public health issue
DEFINING IPV

• Many different definitions
• Most definitions include physical abuse, psychological/emotional abuse, and sexual assault
• Prevalence rates vary significantly between current, recent, and lifetime abuse
• Earlier studies were often limited to physical abuse
Intimate partner violence is a pattern of assaultive and coercive behaviors including:

- Inflicted physical injury
- Psychological abuse
- Sexual assault
- Progressive social isolation
- Stalking
- Deprivation
- Intimidation and threats

Family Violence Prevention Fund, 2002
IPV was a precipitating factor in

52.2% of female homicides

{ IPV was a precipitating factor in nearly one-third of suicides }

CDC, 2009
Approximately three-quarters (73.7%) of all murder-suicides involved an intimate partner.

Violence Policy Center, 2006
Lifetime prevalence of physical and/or sexual IPV among women from 10 different countries ranged from 15% to 71%.

World Health Organization, 2005
24.8% of women
7.6% of men

Lifetime prevalence of having been raped and/or physically assaulted by a current or former partner:

Tjaden & Thoennes, 2000
60,799 victims served in one day

National Network to End Domestic Violence, 2008
84% of spouse abuse victims are female

Bureau of Justice Statistics, 2005
African American, Native American, and Hispanic women are at significantly greater risk for IPV

Silverman et al, 2006; Field & Caetano, 2005
Prevalence rates of IPV in the past year among women seen at a community health care system:

- 18.5% disclosed physical violence
- 14.4% disclosed sexual coercion
- 72.6% disclosed psychological aggression

Hazen & Soriano, 2007
Couples with IPV are more likely to be economically vulnerable and live in disadvantaged neighborhoods.

Fox & Benson, 2006
60% of homeless young adults disclosed abuse by a current partner

Boris et al, 2002
SPECIAL POPULATIONS

• Prevalence among same-sex couples varies by gender of the couple and by the perpetrator’s gender

• Persons with disabilities are at high risk for IPV

Hathaway et al, 2000; McFarlane et al, 2001; Tjaden & Thoennes, 2000
400,000 adolescents experience serious physical and/or sexual dating violence

Wolitzky-Taylor et al, 2008
1 in 10 to 1 in 5 high school-aged teens are hit, slapped, or beaten by a dating partner each year

Wolfe et al, 2009
Teens experiencing physical dating violence are more likely to engage in:

– Sexual intercourse
– Suicide attempts
– Episodic heavy drinking
– Physical fighting

MMWR, 2006
15.5 MILLION CHILDREN have been exposed to physical IPV in the past year

McDonald et al, 2006
IPV is associated with

8 of the 10

Leading Health Indicators for Healthy People 2010
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CONNECTION WITH IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use</td>
<td>Increased risk of smoking (Hathaway et al, 2000)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Increased risk of high risk alcohol use (Lemon et al, 2002)</td>
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<td>Injury &amp; Violence</td>
<td>Leading cause of injuries and homicide (Frye et al, 2001)</td>
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<tr>
<td>Mental Health</td>
<td>Increased risk of mental health problems (Coker et al, 2002)</td>
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## HEALTHY PEOPLE 2010

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CONNECTION WITH IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Sexual Behavior</td>
<td>Increased sexual risk-taking and STIs (Coker, Sexual Behavior, 2000); Less likely to use condoms consistently (Wingood et al, 2001)</td>
</tr>
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<td>Access to Health Care</td>
<td>Increased risk of late entry into prenatal care (McFarlane et al, 1992; Silverman et al, 2006)</td>
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<td>Immunizations</td>
<td>Children of battered women less likely to get immunizations (Attala et al, 1997; Bair-Merritt et al, 2008; Webb et al, 2001)</td>
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<td>Body Weight</td>
<td>Overweight &amp; Current body mass &gt;25 (Black &amp; Breiding, Obesity, 2008); weight gain (Sato-DiLorenzo &amp; Sharps, 2007)</td>
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IPV costs the USA economy $12.6 Billion on an annual basis

Waters et al, 2004
• To integrate culturally relevant prevention, screening, intervention, and referral strategies for IPV into the public health setting
PUBLICATION RESPONSE: ESSENTIAL STEPS

- Develop partnerships with local domestic violence programs
  - Join or create multidisciplinary task forces to promote a coordinated community response to IPV
  - Conduct community needs assessments
PUBLIC HEALTH RESPONSE: ESSENTIAL STEPS

• Establish policies to institutionalize routine screening in public health settings
  • Develop, implement, and monitor protocols for IPV in public health agencies
  • Integrate IPV curricula into schools of public health, nursing, and medicine
PUBLIC HEALTH RESPONSE: ESSENTIAL STEPS

- Enhance data collection and dissemination
- Promote social marketing campaigns and community education
- Increase funding for science-based, public health approaches
- Provide technical assistance and evaluation
- Advocate for local, state, and national policy reform
PUBLIC HEALTH RESPONSE: ESSENTIAL STEPS

- Ongoing training for public health professionals
- Implement policies to improve the safety of victims and employees in the workplace
- Ensure that employee assistance programs have protocols
VISION FOR SUCCESS

Public Health brings special skills and a unique perspective to address IPV:

- Prevention focus
- Working collaboratively across disciplines
- Scientific, data-based approach
- Long tradition of promoting social change and prevention
ASSESSMENT IS THE FIRST STEP OF INTERVENTION

Listening and affirmation are invaluable to victims.
Primary Prevention:

For clients who are not experiencing abuse, screening affirms that IPV is an important health care issue and provides an opportunity to talk about healthy relationships and the warning signs of an abusive relationship.
Secondary Prevention:

In the early stages of an abusive relationship, early identification and intervention can prevent serious injuries and chronic illnesses as the violence escalates and the entrapment increases.
Tertiary Prevention:

In relationships with escalating violence, screening provides the opportunity for disclosure in a safe and confidential environment. Even if clients do not feel safe disclosing their abuse, giving supportive messages can end their isolation and let them know that they have options.
PROMISING PRACTICES:
STATE OF FLORIDA DEPARTMENT OF PUBLIC HEALTH

• State and local health departments partnered with domestic violence agencies to create screening guidelines
• Regional train-the-trainers sessions with teams of domestic violence advocates and health department staff
• Training teams train staff in their counties
Regional and Local Data
POTENTIAL DATA SOURCES

- PRAMS
- BRFSS
- YRBSS
- NVDRS
- Client surveys & needs assessments
- Child protective services
- Chart audits
- Fatality review teams
POTENTIAL DATA SOURCES

• Police data
• Trauma registries
• Domestic violence programs
• 911 Dispatch logs
• Hotline statistics
• Restraining orders
– Surveillance methods linked multiple data sources
– Homicide was the leading cause of maternal injury-related deaths
– Majority (89%) of homicide deaths occurred in the late post-partum period
– Two-thirds of homicide deaths were known or alleged cases of IPV

MA Maternal Mortality and Morbidity Review, 2002
TOPICS COVERED IN THIS CURRICULUM

• Overview
• Regional and Local Data
• Medical Cost Burden and Health Care Utilization for IPV
• Impact of IPV on Women’s Health
• IPV and Behavioral Health
• IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, & Unintended Pregnancy
• IPV and Sexually Transmitted Infections & HIV
• IPV and Perinatal Programs
• IPV and Breastfeeding and Nutritional Supplements
• IPV and Child and Adolescent Health
• IPV and Adverse Childhood Experiences
• IPV and Violence and Injury Prevention
• IPV and Home Visitation
Each topic is organized as follows:

- Learning Objectives
- Overview and Statistics
- Implications
- Strategies
- Promising Practices
- Defining Success

*Additional information for each slide is provided in the “notes” viewing option*
Public Health Response to IPV

R - Recognize the problem
E - Educate the public
S - Screen routinely
P - Primary prevention focus
O - Ongoing staff education
N - New data sources
S - Strategies for intervention
E - Engage with community partners
MEDICAL COST BURDEN AND HEALTH CARE UTILIZATION FOR IPV
The medical costs for IPV within the first 12 months after victimization:

$4 to $7 Billion

Brown et al, 2008
ATTRIBUTABLE COSTS ASSOCIATED WITH IPV FOR WOMEN:

Brown et al, 2008
Recently abused women have health care costs that are more than twice those of never abused women.
HMO COSTS HIGHER FOR IPV

• Average health care costs for women disclosing IPV were $1700 higher compared to never abused women over a 3-year period.

• Using this estimate, an insurer with 300,000 female enrollees could expect $2 million in additional claims over a 3-year period.

Jones et al, 2006
Total annual health care costs were:

- **42%** higher for women experiencing ongoing physical abuse

  - **24%** higher for women who experienced physical abuse within the past 5 years

  - **19%** higher for women who experienced physical abuse more than 5 years ago

Jones et al, 2006
Women who reported injuries as a consequence of their most recent IPV victimization utilized the following services due to their injuries (mean number of visits):

- **2** ED visits
- **3.5** physician visits
- **5.2** dental visits
- **19.7** physical therapy visits

Arias & Corso, 2005
MENTAL HEALTH SERVICES

• Regardless of whether the abuse was physical or non-physical, abused women have higher mental health utilization

• Mental health care utilization was higher for recent (past 5 years) and remote (more than 5 years ago) IPV

Bonomi et al, 2009
Women with recent nonphysical abuse (only) had annual health care costs that were **33% higher** than non-abused women.

recent=in past 5 years
Bonomi et al, 2009
Women experiencing more severe IPV:

- are 3 times more likely to have a total expenditure of over $5000

- Have health care expenditures twice that of non-abused women

Coker et al, 2004
Women reporting any IPV during pregnancy were more than TWICE as likely to experience an antenatal (before birth) hospitalization not associated with delivery

Lipsky et al, 2004
Children whose mothers disclosed severe IPV had TWICE the number of ED visits at 18 months follow-up

Bair-Merritt et al, 2008
Children exposed to IPV after they are born are 3 TIMES more likely to use mental health services.

Rivara et al, 2007
The Impact of IPV on Women’s Health
The Impact of IPV on Women’s Health
LEARNING OBJECTIVES

1. Identify three health conditions that are associated with IPV or dating violence
2. Describe two ways that IPV may impact women’s/teens’ health care services
3. List two strategies for responding to IPV
PREVALENCE IN THE CLINICAL SETTING

IPV among women enrolled in a health maintenance organization:

- Lifetime: 44.0%
- Past 5 years: 14.7%
- Past year: 7.7%

Thompson et al, 2006
DISEASE BURDEN OF IPV

• 7.9% of the overall disease burden for women, ages 18-44

• Larger risk than common risk factors for disease including blood pressure, tobacco use, and obesity

Vos et al, 2006
Abused women experience a 50% to 70% increase in gynecological, central nervous system, and stress-related problems.

Campbell et al, 2002
Women exposed to ongoing IPV report increased physical symptoms over time

Gerber et al, 2007
More than one-third of female IPV survivors experience high disability chronic pain

Wuest et al, 2008
IPV AND COMORBID HEALTH CONDITIONS

- Arthritis
- Asthma
- Headaches and migraines
- Back pain
- Chronic pain syndromes
- High blood cholesterol
- Heart attack and heart disease
- Stroke
- Depressed immune function

WOMEN WHO HAVE EXPERIENCED IPV ARE MORE LIKELY TO BE DIAGNOSED WITH GI PROBLEMS INCLUDING:

• Stomach ulcers
• Frequent indigestion, diarrhea, or constipation
• Irritable bowel syndrome
• Spastic colon

WOMEN WITH A HISTORY OF IPV ARE MORE LIKELY TO EXPERIENCE:

- Urinary tract and vaginal infections
- Irregular menstrual cycles
- Pain during sex, dysmenorrhea and vaginitis
- Pelvic inflammatory disease
- Chronic pelvic pain syndrome
- Invasive cervical cancer and preinvasive cervical neoplasia

Campbell et al, 2002; Coker et al, 2000; Letourneau et al, 1999; Mark et al, 2008; Shei, 1991
Women who have experienced IPV are more likely to be diagnosed with invasive cervical cancer

Coker et al, 2009
ABUSED WOMEN ARE MORE LIKELY TO:

- not have a mammogram
- have more prescriptions
- have more emergency room visits
- have more physician visits

Farley et al, 2002; Kernic et al, 2000; Letourneau et al, 1999; Sansone et al, 1997; Wisner, 1999
Women with a history of IPV have:

1.6X

higher rates of medical care utilization and higher health care costs

Ulrich et al., 2003
Health problems associated with a history of forced sex by an intimate partner include:

- Chronic headaches
- Depression
- Pelvic inflammatory disease
- Vaginal and anal tearing
- Bladder infections
- Sexual dysfunction
- Pelvic pain
- Gynecological problems

Bergman & Brismar, 1991; Bonomi et al, 2007; Campbell & Lewandowski, 1997; Campbell & Alford, 1989; Chapman JD, 1989; Dienemann et al, 2000; Domino & Haber, 1987; Plichta, 1996
IMPLICATIONS FOR WOMEN’S HEALTH

• IPV is a hidden risk factor for many common women’s health problems

• Screening provides an opportunity for women to make the connection between victimization, health problems, and risk behaviors
"I want to understand how violence affects me mentally and physically... so I can learn to avoid bad situations." -woman at crisis center

Wilson et al, 2007
Cancelled and missed appointments, interrupted care and noncompliance with treatment and follow-up may be related to victimization
17% of abused women reported that a partner prevented them from accessing health care compared to 2% of non-abused women

McCloskey et al, 2007
Implement an IPV protocol:

- Routine assessment
- Health and danger assessment tools
- Documentation skills and confidentiality
- Safety planning strategies
- Cultural competency
- Resources and referrals
WOMEN WHO TALKED TO THEIR HEALTH CARE PROVIDER ABOUT THE ABUSE WERE:

~4 times more likely
to use an intervention

2.6 times more likely
to exit the abusive relationship

McCloskey et al, 2006
WOMEN, CO-OCCURRING DISORDERS & VIOLENCE STUDY (WCDVS)

- 9 different sites with over 2000 women
- Integrated services
  - Trauma Recovery & Empowerment (TREM)
  - Seeking Safety
  - Addiction and Trauma Recovery Integration Model (ATRIUM)

SAMHSA, 2003
LESSONS LEARNED FROM WCDVS

• Trauma- and survivor-informed approaches are essential to effective services

• Gender-specific services are critical to create a healing environment

• Group environments are key to restoring trust & promoting healing

• Integrating trauma, mental health, & substance abuse services increases effectiveness
Educational materials, ongoing training

Partner with an advocacy organization

Establish policies and protocols

Integrate into standardized forms

Reimbursement strategies

MORE
WOMEN’S HEALTH: SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
CCM Strategies include:

- Using case managers to support clients
- Implementing decision support systems to reduce providers’ fear of addressing IPV
- Developing self-support tools to help clients with safety planning and managing comorbid conditions
- Formalizing collaboration with community agencies to improve access to resources

Nicolaidis & Touhouliotis, 2006
Partnership project based at seven community health centers in Boston, MA:

- Direct services for IPV victims on-site at health centers
- Training for providers and staff
- Linkage between clinics and community-based domestic violence programs
PROMISING PRACTICE:
UNIVERSAL SCREENING COMMUNITY HEALTH CENTER

• Implemented screening protocol to screen all patients
• 39% screening rate
• 93% documentation rate
• 1-hour protocol refresher built into nurses’ recertification

Thurston et al, 2007
Agreement between local clinics and the crisis center to waive the clinics’ co-payment for women who are referred from the crisis center.

Wilson et al. 2007
Download at:

Basile et al, 2007
DEFINING SUCCESS

✓ Safe environment for disclosure
✓ Supportive messages
✓ Educate about the health effects of IPV
✓ Offer strategies to promote safety
✓ Inform about community resources
✓ Create a system-wide response
DEFINING SUCCESS

"Success is measured by our efforts to reduce isolation and to improve options for safety."

Family Violence Prevention Fund
• Women with restraining orders received 6 telephone calls from a nurse to promote safety behaviors over 8 weeks

• Women who received the intervention had more safety behaviors

McFarlane et al, 2004
Intimate Partner Violence (IPV) and Behavioral Health
1. Identify two mental health conditions associated with IPV victimization.
2. Describe the link between substance abuse and IPV victimization and perpetration.
3. Describe two promising practice strategies for addressing IPV within the behavioral health setting.
Depression, anxiety, and suicide together contributed to 73% of the total disease burden associated with IPV

Vos et al, 2006
Abused pregnant Latina women have more than TWICE the odds of experiencing depression or PTSD.

Rodriguez et al, 2008
HALF of the abused women referred from an emergency room had symptoms of PTSD

Lipsky et al, 2005
Among women who experienced IPV in the past year: 20% — 38% have symptoms of depression

Caetano & Cunradi, 2003
Past or current abuse is a risk factor for postpartum depression

Kendall-Tackett, 2007
Black women with a history of lifetime abuse were 9.3 times more likely to report depression than non-abused Black women.
Psychological abuse by an intimate partner was a stronger predictor than physical abuse for the following health outcomes for female and male victims:

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

Coker et al, 2002
IPV AND MENTAL HEALTH COMORBIDITIES:

- Anxiety
- Sleep problems
- Memory loss
- Post-traumatic stress disorder
- Depression
- Panic attacks, insomnia
- Suicide ideation/actions

The suicide risk is 5x higher among abused women who are sexually assaulted by their partners

McFarlane et al, 2005
IPV: RISK FACTOR FOR SUBSTANCE ABUSE

- Abused women are at increased risk for substance abuse
- Spousal abuse scores are the strongest predictor of alcoholism in women
- IPV during the first year of marriage is highly predictive of heavy, episodic drinking one year later

Kaysen et al, 2007; Miller et al, 1989; Plichta, 1992
Women experiencing abuse are:

- **2.6X** more likely to use tranquilizers, sleeping pills, or sedatives
- **3.2X** more likely to use anti-depressants
- **2.2X** more likely to use prescription pain pills

Carbone-Lopez et al, 2006
59.1% of women who screened positive for drinking problems experienced IPV in the past year.

Weinsheimer et al, 2005
Women who are physically abused during pregnancy are 7.8 times more likely to drink while pregnant.
Male perpetration of IPV and alcohol abuse are linked

Magdol et al, 1997; Rhodes et al, 2002; Weinsheimer et al, 2005
IPV perpetrators are:

2.5 times more likely to report heavy drinking

4 times more likely to report illicit drug use

Lipsky et al, 2005
Adolescents reporting dating violence are more likely to:

- Consume alcohol
- Smoke tobacco
- Use drugs
- Have suicidal thoughts

Ackard et al, 2003
Dating violence perpetrators (male and female) are more likely to:

- have their first drink before 15 y.o.
- have been drunk in the past 30 days
- used marijuana in the past 30 days

Champion et al, 2008
The long-term consequences of psychological abuse are often minimized or overlooked.

IPV can impact access to behavioral health services and the process of recovery.
A partner’s alcohol abuse is a risk factor for more severe and chronic IPV and the risk of mental health sequelae for the victim.

Substance abuse may be a coping behavior for IPV victims with trauma symptoms.
Integrate assessment for lifetime exposure to violence and perpetration of relationship violence into behavioral health

Assess for trauma symptoms and underlying causes for substance abuse/self-medicating

Fully protect the confidentiality of victims’ health records
STRATEGIES FOR BEHAVIORAL HEALTH PROGRAMS

• Ensure that behavioral health services are trauma-informed

• Prioritize the creation of integrated services for on-site services and advocacy for IPV in the behavioral health setting

• Promote cross-training and collaboration between behavioral health and domestic violence programs
BEHAVIORAL HEALTH: SYSTEM LEVEL RESPONSE

- Educational materials, ongoing training
- Partner with an advocacy organization
- Establish policies and protocols
- Integrate into standardized forms
- Reimbursement strategies
BEHAVIORAL HEALTH:
SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
PROMISING PRACTICE: 
BRIEF MENTAL HEALTH SCREEN FOR IPV

• 4-question screen was tested with IPV victims in an emergency department
• Tool is highly predictive for depression & PTSD symptoms and moderately predictive for suicide ideation

Houry et al, 2007
PROMISING PRACTICE: INTEGRATED SCREENING

• “Point of Care Guide” screening tool
• 6 validated questions to screen for alcohol, depression, & IPV and interpretation instructions

Bell, 2004
This substance abuse treatment and prenatal care program implemented the following strategies:

- Ongoing IPV training
- Patient case review sessions
- Domestic violence staff integrated into interdisciplinary care team
DEFINING SUCCESS

✓ Safe environment for disclosure
✓ Supportive messages
✓ Educate about the mental health effects of IPV
✓ Offer strategies to promote safety
✓ Inform about community resources
✓ Create a system-wide response
DEFINING SUCCESS

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Family Violence Prevention Fund
Intimate Partner Violence (IPV) and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
LEARNING OBJECTIVES

1. Describe the link between IPV and two sexual risk behaviors
2. Identify two ways that IPV can impact family planning services
3. Describe two strategies for responding to IPV in the family planning setting
VIOLENCE AND REPRODUCTIVE HEALTH ARE STRONGLY LINKED

Unplanned pregnancies increase women’s risk for violence

Violence increases women’s risk for unplanned pregnancies
1 in 4 (25%) U.S. women and
1 in 5 (20%) U.S. teen girls report ever experiencing physical and/or sexual IPV.

I'm not gonna say he raped me... he didn't use force, but I would be like, "No," and then, next thing, he pushes me to the bedroom, and I'm like, "I don't want to do anything," and then, we ended up doin' it, and I was cryin' like a baby, and he still did it. And then, after that... he got up, took his shower, and I just stayed there like shock...

Miller et al, 2007
Women experiencing physical and emotional IPV are more likely to report not using their preferred method of contraception in the past 12 months (OR=1.9).

Williams et al, 2008
IPV increases women’s risk for
UNINTENDED PREGNANCIES

Sarkar, 2008
In a study of adolescent girls who experienced IPV:

- 32.1% become pregnant while in an abusive relationship
- 58.8% reported those pregnancies were unwanted

Miller et al, 2007
Prevalence of physical and/or sexual IPV among women seeking abortions:

**Lifetime:** 27.3% - 39.5%

**Past year:** 14.0% - 21.6%

The risk of being a victim of IPV in the past year was nearly \textbf{3X HIGHER} for women seeking an abortion compared to women who were continuing their pregnancies.

Bourassa & Berube, 2007
IPV AND ABORTION

• 8.8% of abused women seeking an abortion had injuries to their genital areas (Keeling et al, 2004)

• IPV was twice as common among women who chose not to disclose the abortion to their partners

Woo et al, 2005
1 IN 5 WOMEN seeking a repeat abortion disclosed a history of physical IPV

Fisher et al, 2005
Boys and girls who experience sexual dating violence are more likely to:

– Initiate sex before age 11
– Have sexual intercourse with 4 or more people
– Use alcohol or drugs before sex

Kim-Goodwin et al, 2009
Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls

Roberts et al, 2005
Women who were sexually abused as children are more than *twice as likely* (58.6% vs. 24.9%) to have unprotected sex compared to women who did not experience CSA.

Fergusson et al, 1997
Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships.

Raj et al, 2007
DATING VIOLENCE AND CONDOM USE

Adolescent girls who experience dating violence are half as likely to use condoms consistently.

Wingood et al, 2001
Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid.

—I 17-yr-old female who started Depo-Provera without partner’s knowledge

Miller et al, 2007
Tactics used by IPV perpetrators include:

- Destroying or disposing of contraceptives
- Impeding condom use (threatening to leave her, poking holes in condoms)
- Not allowing her to obtain or preventing her from using birth control
- Threatening physical harm if she uses contraceptives

Among teen mothers on public assistance who experienced recent IPV:

- 66% experienced birth control sabotage by a dating partner.
- 34% reported work or school-related sabotage by their boyfriend.

Raphael, 2005
Teen girls who experienced physical dating violence were:

- **2.8 times** more likely to fear consequences of negotiating condom use
- **2.6 times** more likely to fear talking with their partner about pregnancy prevention

Wingood et al, 2001
One-quarter (26.4%) of adolescent females reported that their abusive male partners were trying to get them pregnant.

Miller et al, 2007
Adolescent mothers who experienced physical abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months.

Raneri & Wiemann, 2007
Women who experienced recent physical abuse were more likely to report:

- Male partner control of the relationship
- Fear of partner response to condom negotiation
- No history of male partner testing for HIV

Raj et al, 2004
Men who perpetrated IPV in the past year were more likely to report:

- Inconsistent or no condom use during vaginal and anal sexual intercourse
- Forcing sexual intercourse without a condom

Raj et al, 2006
IMPLICATIONS FOR FAMILY PLANNING

- Sexual assault by an intimate partner is rarely detected or disclosed without screening.
- Many victims do not have control over their sexual decision-making.
- Teens should be assessed for dating violence and its impact on reproductive health choices.
IMPLICATIONS FOR FAMILY PLANNING

• Family planning and birth control options may be limited or sabotaged by an abuser.
• The violence may escalate if victims use or try to negotiate birth control/family planning options.
• Help clients negotiate self-care in the context of an abusive relationship.
• Implement routine screening
  – include clients seeking emergency contraceptives and abortions

• Include specific questions for sexual assault
  – “Has anyone forced you to have sexual activities when you did not want to?”
FAMILY PLANNING: SYSTEM LEVEL RESPONSE

- Educational materials, ongoing training
- Partner with an advocacy organization
- Establish policies and protocols
- Integrate into standardized forms
- Reimbursement strategies

MORE ▶▶
FAMILY PLANNING:
SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
**PROMISING PRACTICES: CALIFORNIA**

- Provides reproductive health care for low income women and men
- Screening questions on standardized forms
- Routine screening for sexual assault at EC visits
- Educational materials for providers and clients
- Reimbursement codes for IPV counseling

FamilyPACT Program
**PROMISING PRACTICES: PENNSYLVANIA**

- Four rural family planning clinics
- Partnership with local shelters
- Ongoing training and technical support
- Sustained an increase in screening and referrals six months after training implemented

Ulbrich and Stockdale, 2002
Collaboration between clinic and local shelters

Two hour in-training

Instituted an assessment protocol

Increased assessment from 0 to 61%

Increased disclosure of abuse from 0 to 11.5%
RESOURCES

- Annotated Bibliography on the Impact of Childhood Sexual Abuse, Dating Violence, and Intimate Partner Violence on Reproductive Health
- Family Violence Reproductive Health Program Assessment Tool

www.amchp.org
www.endabuse.org
RESOURCES

• Strategies on how to integrate assessment for violence and reproductive coercion into clinical practice
• Scripts for assessment

www.knowmoresaymore.org
Reproductive Health Safety Card

- Asks key questions
- Used as a prompt for staff and a safety card for patients
- Order at endabuse.org/health
DEFINING SUCCESS

- Safe environment for disclosure
- Supportive messages
- Educate about the health effects of IPV
- Offer strategies to promote safety
- Inform about community resources
- Create a system-wide response
Success is measured by our efforts to reduce isolation and to improve options for safety.

Family Violence Prevention Fund
Intimate Partner Violence (IPV) and Sexually Transmitted Infections/HIV
1. Describe two ways that IPV can increase the risk of STIs/HIV
2. Give two examples of how IPV can impact treatment outcomes for STIs/HIV
3. Identify two strategies to improve STIs/HIV programs’ response to IPV
Women who experienced past or current IPV are more likely to:

- Have multiple sexual partners
- Have a past or current sexually transmitted infection
- Report inconsistent use or nonuse of condoms
- Have a partner with known HIV risk factors

Wu et al, 2003
Under high levels of fear for abuse, women with high STI knowledge were more likely to use condoms inconsistently than nonfearful women with low STI knowledge.

Ralford et al, 2009
Women disclosing physical abuse were 3 TIMES more likely to experience a STI.

Women disclosing psychological abuse were 2 TIMES more likely to experience a STI.

Coker et al, 2000
More than one-third (38.8%) of adolescent girls tested for STI/HIV have experienced dating violence.

DECKER ET AL, 2005
DEPRESSION, IPV, AND STIs
IN A SAMPLE OF PREDOMINANTLY AFRICAN AMERICAN WOMEN

Women with symptoms of depression and a history of IPV were 19 TIMES more likely to have been treated for a STI in the past year.

Laughon et al, 2007
Research shows us that violence is both a significant cause and a significant consequence of HIV infection among women.

Judy Auerbach
American Foundation for AIDS Research (AmfAR)
Women who are HIV-positive experience more severe IPV and more frequent abuse compared to HIV-negative women who are experiencing IPV.

Review study by Gielen et al, 2007
Based on a study of 310 HIV-positive women:

- 68% experienced physical abuse as adults
- 32% experienced sexual abuse as adults
- 45% experienced abuse after being diagnosed with HIV

Gielen et al, 2000
HIV AND IPV

Among a small sample of HIV-positive men:

- 39% reported physical IPV by a primary sexual partner
- 17% reported physical IPV by a casual sexual partner

Shelton et al, 2005
Women who engaged in sex with an HIV-infected partner or an injecting drug user were more likely to have experienced recent physical or sexual IPV.
HIV-positive men and women who experienced IPV were more likely to engage in unprotected sex.

Bogart et al, 2005
HIV-positive women who experienced recent IPV were more likely to report:

- inconsistent condom use
- pregnancy
- abuse stemming from requests for condom use

Lang et al, 2007
IPV is an **UNDER-RECOGNIZED BARRIER** to women’s ability to obtain regular medical care for HIV/AIDS.

Lichtenstein, 2006
HIV-positive women who have experienced IPV in the last year reported THE LOWEST HEALTH-RELATED QUALITY OF LIFE.

McDonnell et al, 2005
**IMPLICATIONS**

FOR SEXUALLY TRANSMITTED INFECTIONS/HIV PROGRAMS

- Partner notification may be dangerous for clients experiencing abuse.
- Clients may not be able to negotiate safe sex with an abusive partner.
- IPV may be a more immediate threat to a client than a sexually transmitted infection or HIV status.
HIV counseling and testing programs offer a unique opportunity to identify and assist women at risk for violence and to identify women who may be at high risk for HIV as a result of their history of assault.

Maman et al, 2000
RECOMMENDATIONS
FOR HIV PREVENTION PROGRAMS

• Integrate violence & IPV screening.
• Educate clients about how violence can influence risk behaviors.
• Teach safety planning skills.
• Ensure that staff are trained to address violence/IPV.
• Design program evaluation to include sexual risk reduction and safety from violence.

Teti et al, 2006
STRATEGIES

FOR SEXUALLY TRANSMITTED INFECTIONS/HIV PROGRAMS

Screen Routinely

Educate Clients

Recognize elevated risk of partner notification

Identify most effective treatment options
SEXUALLY TRANSMITTED INFECTIONS/HIV: SYSTEM LEVEL RESPONSE

- **Educational materials, ongoing training**
- **Partner with an advocacy organization**
- **Establish policies and protocols**
- **Integrate into standardized forms**
- **Reimbursement strategies**
SEXUALLY TRANSMITTED INFECTIONS/HIV: SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
DEFINING SUCCESS

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DEFINING SUCCESS

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

– Family Violence Prevention Fund
PROMISING PRACTICE: URBAN HIV PRIMARY CARE CLINIC

• Medical chart review with a random sample of 25% of initial visits
• 3% of cases had documented queries for IPV
• Implemented training program to:
  – routinize documentation
  – offer follow-up psychosocial evaluations
  – increase access to community services

Wolfe et al, 2003
PROMISING PRACTICE: HIV/STD INTERVENTION FOR ABUSED WOMEN

• Randomized controlled trial
• Women recruited from family planning clinic
• Abused women who received 8-session intervention were more likely to:
  – decrease unprotected sex occasions or maintain safer sex
  – have a safer sex discussion with their main partner

Melendez et al, 2003
PROMISING PRACTICES:
CALIFORNIA DEPARTMENT OF HEALTH
HIV/SEXUALLY TRANSMITTED DISEASE PREVENTION TRAINING CENTER

• IPV screening and intervention is part of the core training for new HIV testing counselors and STD service providers
• Provides cross-training between STD/HIV programs and domestic violence programs
• Developed a policy on partner notification for clients disclosing abuse
The State of Florida Department of Health is required to include information about “domestic violence and the risk factors associated with domestic violence and AIDS” as part of their program to educate the public about AIDS.

Title XXIX,. 381.0038 Education, 2002 Florida Statutes
Intimate Partner Violence (IPV) and Perinatal Programs
1. Identify three pregnancy complications associated with IPV
2. Describe two risk behaviors during pregnancy that are associated with IPV
3. Discuss two strategies to address IPV in the perinatal setting
Homicide is the **second** leading cause of injury-related deaths among pregnant women.
A significant proportion of all female homicide victims are killed by their intimate partners.

Frye et al, 2000; Massachusetts, 2002
Pre-incident factors associated with a woman being killed by her abusive partner include:

- threatening with a weapon
- estrangement from a controlling partner
- stalking
- forced sex
- abuse during pregnancy

Campbell et al, 2003
IPV BEFORE AND DURING PREGNANCY

Based on data from population-based, statewide surveys of new mothers:

- 5.3% experienced physical abuse during pregnancy
- 7.2% experienced physical abuse during the 12 months preceding pregnancy

Saltzman et al, 2003
In a multistate study of pregnant women with or at risk for HIV:

- **8.9%** experienced physical and/or sexual IPV during pregnancy
- **4.9%** experienced IPV within six months after delivery

Koenig et al, 2006
POSTPARTUM ESCALATION OF ABUSE

Among women who experienced abuse before and during pregnancy, the frequency of physical abuse increased during the postpartum period.

Stewart et al, 1994
20%-25% of pregnant teens reported physical or sexual abuse during pregnancy.

Berenson et al, 1992; Parker et al, 1993 & 1994
Boyhood exposure to IPV is associated with an increased risk of male involvement in a teen pregnancy.

Anda et al, 2001
Infants born to women who are physically abused during pregnancy are at greater risk of death.

Ahmed 2006; Yost et al, 2005
PHYSICAL IPV IN THE 12 MONTHS PRIOR TO PREGNANCY INCREASES THE RISK OF:

- High blood pressure or edema
- Vaginal bleeding
- Severe nausea, vomiting or dehydration
- Kidney infection or urinary tract infection
- Hospital visits
- An infant requiring intensive care unit stay

Silverman et al, 2006
Women experiencing physical IPV during pregnancy are 2.7 times more likely to have a pregnancy-related hospitalization compared to non-abused pregnant women.

Lipsky et al, 2004
Women who experience physical abuse are 3 TIMES more likely to deliver a low birth weight infant.

Yost et al, 2005
IPV DURING PREGNANCY IS ASSOCIATED WITH:

- **Lower gestational weight gain during pregnancy** (Moraes et al, 2006)
- **Birth weight** (Kearney et al, 2004)
  - Pre-term LBW and term LBW (Coker et al, 2004)
  - Low and very low birth weight (Lipsky et al, 2003)
- **Pre-term births** (Silverman et al, 2006; Valladares et al, 2003)
COMPLICATIONS DURING PREGNANCY: TEENS

- Pregnant teens who experienced abuse were more likely to miscarry than their non-abused peers (Jacoby et al, 1999)
- Prenatal violence was a significant risk factor for pre-term birth among pregnant adolescents (Covington et al, 2001)
WOMEN WHO EXPERIENCE ABUSE AROUND THE TIME OF PREGNANCY ARE MORE LIKELY TO:

- Smoke tobacco
- Drink during pregnancy
- Use drugs
- Experience depression, higher stress, and lower self-esteem
- Attempt suicide
- Receive less emotional support from partners

Amaro, 1990; Bailey & Daugherty, 2007; Berenson et al, 1994; Campbell et al, 1992; Curry, 1998; Martin et al, 2006; Martin et al, 2003; Martin et al, 1998; McFarlane et al, 1996; Perham-Hester & Gessner, 1997
Women who experience physical abuse during pregnancy are 4.5X more likely to use illicit drugs while they are pregnant.
42% of women experiencing some form of IPV could not stop smoking during pregnancy compared to 15% of non-abused women.

Bullock et al, 2001
Women with a controlling or threatening partner are 5X more likely to experience persistent symptoms of postpartum maternal depression.

Blabey et al, 2009
Women who reported IPV during pregnancy or the year prior to pregnancy were:

- less likely to receive prenatal care in the first trimester
- more likely to report smoking during the third trimester

Silverman et al, 2006
24% higher health care costs for children whose mothers’ IPV stopped before the child was born.

Rivara et al, 2007
Mothers who experienced IPV were more likely to have maternal depressive symptoms and report harsher parenting.

Mothers’ depression and harsh parenting were directly associated with children’s behavioral problems.

Dubowitz et al, 2001
Families with IPV are **2X AS LIKELY** to have a substantiated case of child abuse compared to families without IPV.

Rumm et al, 2000
IMPLICATIONS FOR PERINATAL PROGRAMS

- Assessment provides a unique opportunity for early intervention
- Pregnant women in abusive relationships are high-risk pregnancies
- Risk behaviors such as smoking and drinking during pregnancy are highly correlated with IPV
“I use rocking, hurting myself, and scribbling to keep safe, these clear my head....”

– abused pregnant teen

Renker, 2002
Health care providers need to ask not only if the teenager is experiencing violence but also how she copes with it.

– P.R. Renker

Renker, 2002
STRATEGIES FOR PERINATAL PROGRAMS

• Screen routinely.
• Target education and resources to pregnant adolescents.
• Integrate IPV into training for perinatal providers.
• Make the connection between IPV and perinatal health.
STRATEGIES FOR PERINATAL PROGRAMS

- Include information on IPV as part of client education and parent resource packets.
- Ask mothers about IPV in private during home visits.
- Incorporate IPV into perinatal protocols.
STRATEGIES FOR PERINATAL PROGRAMS

• Integrate assessment and intervention for IPV into substance abuse and smoking cessation programs for pregnant women
• Include information on IPV and the effects of violence on children and brain development in parenting classes/resources
PERINATAL PROGRAMS: SYSTEM LEVEL RESPONSE

1. Educational materials, ongoing training
2. Partner with an advocacy organization
3. Establish policies and protocols
4. Integrate into standardized forms
5. Reimbursement strategies

MORE ▶▶
PERINATAL PROGRAMS:
SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
PROMISING PRACTICE: SCREENING AT A PRENATAL CLINIC

The odds of screening were 7 ½ times greater after the following strategies had been implemented:

- 2-hour training for OB/GYN residents
- Medical record audits to assess screening practices
- Director met with residents
- Residents received individualized screening performance reports at 7-week intervals

Duncan et al, 2006
PROMISING PRACTICE: EMPOWERMENT TRAINING

In a randomized controlled trial, pregnant women who received 30 minutes of empowerment training by a midwife reported:

- Higher physical functioning and improved role limitation due to physical and emotional problems
- Reduced psychological and minor physical abuse

Tiwari et al, 2005
PROMISING PRACTICE: Integrated Intervention to Reduce IPV during Pregnancy

- Randomized controlled trial with 1044 African American women
  - Nearly one-third (32%) reported IPV in the past year

- Intervention delivered during prenatal care by social worker or psychologist (average 35 ± 15 mins)
  - Counseling also addressed depression and tobacco use

- Women who received intervention were less likely to have recurrent IPV, ↓ very preterm neonates, and ↑ mean gestational age

Kiely et al, 2010
DEFINING SUCCESS

✓ Safe environment for disclosure
✓ Supportive messages
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DEFINING SUCCESS

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Family Violence Prevention Fund
IPV, Breastfeeding, and Nutritional Supplement Programs
Intimate Partner Violence (IPV), Breastfeeding, and Nutritional Supplement Programs
LEARNING OBJECTIVES

1. Describe the connection between breastfeeding and IPV.
2. Identify two strategies for addressing IPV in a nutritional supplement program such as WIC.
3. Describe two system level responses for addressing IPV.
Women who experience physical and/or psychological IPV during pregnancy are less likely to initiate breastfeeding.

Lau & Chan, 2007
Women experiencing physical abuse around the time of pregnancy are:

- 35%-52% less likely to breastfeed their infants
- 41%-71% more likely to cease breastfeeding by 4 weeks postpartum

Silverman et al, 2006
Women who were eligible for WIC benefits were 3 TIMES more likely to disclose IPV at well-child visits than women who were not eligible for WIC benefits.

Parkinson et al, 2001
IMPLICATIONS FOR BREASTFEEDING AND NUTRITIONAL SUPPLEMENT PROGRAMS

- Opportunity to screen mothers and children that may have limited access to other services due to violence in the household.
  - Breastfeeding may not be a safe choice for IPV victims and their infants.
Abusive partners may use tactics such as withholding food to control a victim.

A woman in an abusive relationship may not have control over what she and her children eat.

Poor compliance with dietary recommendations may be related to abuse.
IMPLICATIONS FOR BREASTFEEDING AND NUTRITIONAL SUPPLEMENT PROGRAMS

• Integrate IPV screening questions into nutritional assessment forms.
• Counsel clients about the potential of escalating abuse during breastfeeding and discuss strategies to increase personal safety.
• Help clients develop strategies to comply with dietary recommendations.
• Provide ongoing IPV training for staff.
IMPLICATIONS FOR BREASTFEEDING AND NUTRITIONAL SUPPLEMENT PROGRAMS

• Integrate information on IPV and the impact on children into pamphlets, videos, and resources.

• Conduct research on the impact of IPV on the nutritional status of women, infants, and children.
BREASTFEEDING AND NUTRITIONAL PROGRAMS: SYSTEM LEVEL RESPONSE

- Educational materials, ongoing training
- Partner with an advocacy organization
- Establish policies and protocols
- Integrate into standardized forms
- Reimbursement strategies

MORE
BREASTFEEDING AND NUTRITIONAL PROGRAMS: SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
The School of Social Work at Florida State University developed IPV resources for WIC workers, other nutrition staff, and elder care workers:

– Online tutorials
– Competency-based training manuals
DEFINING SUCCESS

- Safe environment for disclosure
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- Offer strategies to promote safety
- Inform about community resources
- Create a system-wide response
DEFINING SUCCESS

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Family Violence Prevention Fund
Intimate Partner Violence (IPV) and Child and Adolescent Health
1. List three physical health problems associated with childhood exposure to IPV
2. Identify two mental health conditions that are associated with childhood exposure to IPV
3. Describe two promising practices for children exposed to IPV
Home is the site of more violence against women and girls than any other location

Chrisler & Ferguson, 2006
The risk of child abuse is 3 TIMES higher in families with IPV

Lee et al, 2004; McGuigan & Pratt, 2001
A wide range of experiences for children whose caregivers are being physically, sexually, or emotionally abused:

– observing a caregiver being harmed, threatened, or murdered
– overhearing these behaviors
– being exposed to the physical and/or emotional aftermath of a caregiver’s abuse

Jaffe et al, 1990; McAlister, 2001
Childhood exposure to IPV increases the risk of under-immunization

Bair-Merritt et al, 2006
Children of mothers who disclosed IPV are:

• Less likely to have 5 well-child visits within the first year of life
• Less likely to be fully immunized at age 2

Bair-Merritt et al, 2008
The organization of a developing brain is reinforced by experience as it adapts to its environment.

The neurobiology of a developing brain can be altered by chronic stress/trauma.

Anda et al, 2006; Teicher, 2002
NEUROBIOLOGICAL IMPLICATIONS OF CHILDHOOD EXPOSURE TO VIOLENCE

- Persistent physiological hyperarousal & hyperactivity
- Profound sleep disturbances
- Difficulty attaching to others
- Lack of empathy
- Aggressive and impulsive behaviors

Perry, 1997; Kuelbs, 2009
Mothers who experience IPV around the time of pregnancy have lower maternal attachment with their infants.

Quinlivan & Evans, 2005
Findings from a meta-analytic review of 118 studies:

63% of children exposed to IPV were faring more poorly than the average child not exposed to IPV

Kitzmann et al, 2003
EXPOSURE TO VIOLENCE INCREASES THE LIKELIHOOD OF CHILDREN EXPERIENCING:

- Failure to thrive
- Bed wetting
- Speech disorders
- Vomiting and diarrhea
- Asthma
- Allergies
- Gastrointestinal problems
- Headaches

Campbell and Lewandowski, 1997; Graham-Bermann & Seng, 2005
CHILDREN EXPOSED TO IPV ARE AT SIGNIFICANTLY HIGHER RISK FOR:

- Posttraumatic Stress Disorder
- Depression
- Anxiety
- Developmental delays
- Aggressiveness

Children exposed to IPV after they are born are 3 TIMES more likely to use mental health services.

English translation: “This is how I see my father because he often gets angry and drunk and his eyes turn red.”

Rivara et al, 2007
Childhood exposure to IPV increases the likelihood of:

- More school nurse visits
- Referral to a school speech pathologist
- Frequent school absences
- Lower grade point averages
- School suspension

Hurt et al, 2001; Kernic et al, 2002
Adolescents exposed to IPV are more likely to:
- Attempt suicide
- Fight
- Carry a gun to school

Yexley et al, 2002
Girls who witnessed violence were 2-3 times more likely to:

- Use tobacco and marijuana
- Drink alcohol or use drugs before sex
- Have intercourse with a partner who had multiple partners

Berenson et al, 2001
IMPLICATIONS FOR CHILD AND ADOLESCENT HEALTH

• Childhood exposure to violence has short-term and long-term consequences
• There is an urgent need for specialized services for children exposed to violence
• Screening and early intervention for childhood exposure to IPV is an opportunity to prevent future violence
STRATEGIES FOR CHILD AND ADOLESCENT HEALTH

• Provide training on the effects of IPV on children
  • Implement protocols on screening and intervention for IPV in the pediatric setting
  • Partner with domestic violence programs that provide education and support services for children
STRATEGIES FOR CHILD AND ADOLESCENT HEALTH

• Integrate counseling services and education on preventing violence into existing child and adolescent health programs

• Incorporate information on childhood exposure to violence into parent education and resource materials
CHILD AND ADOLESCENT HEALTH: SYSTEM LEVEL RESPONSE

- Educational materials, ongoing training
- Partner with an advocacy organization
- Establish policies and protocols
- Integrate into standardized forms
- Reimbursement strategies

MORE...
CHILD AND ADOLESCENT HEALTH: SYSTEM LEVEL RESPONSE

Quality assurance & compliance measures

Facilitate research

Sponsor conferences, education campaigns

Promote cross-training
CHILD AND ADOLESCENT HEALTH: SYSTEM LEVEL RESPONSE

- Create a safe environment for parents and children to talk about the violence
- Develop partnerships with other children’s programs
- Promote evidence-based curricula on violence prevention
- Support policies to improve safety for victims and their children
PROMISING PRACTICES:
CHILD WITNESS TO VIOLENCE PROJECT

• Department of Pediatrics at Boston Medical Center, Massachusetts

• Mental health and advocacy services for young children and families affected by violence

• Provides training and technical assistance for service providers

Groves, 2002
PROMISING PRACTICES: DUAL ADVOCACY

- 10-week intervention for mothers & children
- Mothers received parenting support
- Topics for children included attitudes & beliefs about family violence & building social skills
- 79% fewer children with clinical range externalizing scores & 77% fewer with internalizing scores

Graham-Bermann et al, 2007
PROMISING PRACTICES: STRENGTHENING MOTHER-CHILD RELATIONSHIPS

• 5 pilot sites worked with mothers and their children after leaving domestic violence shelters
• Counseling services focused on strengthening the mother-child bond and were provided at home
• Utilized strengths-based and transfer of learning approach with mothers
• Published parenting booklets/curricula
PROMISING PRACTICES: SCHOOL-BASED INTERVENTION

• 10-session cognitive behavioral group therapy
• Middle school children exposed to violence
• Reduced symptoms of PTSD, depression, and improved psychosocial functioning

Stein et al, 2003
PROMISING PRACTICES: HOME VISITATION

- Weekly home visits for women and children exposed to IPV
- Promoted social support, child management strategies, & nurturing skills
- As a result, children had fewer conduct problems and
- Mothers used less aggressive child management strategies

McDonald, Jouriles, & Skopp, 2006
• Shows the connection between lifetime exposure to violence and parenting outcomes
• Highlights steps for better parenting
• Order at endabuse.org/health
PROMISING PRACTICES:
CARING DADS PROGRAM

• 17-session program for men who have maltreated or exposed their children to IPV
• Therapeutic goals include engaging men and building positive parenting skills
• Includes road map for community planning
RESOURCE:
CONSENSUS GUIDELINES FOR PEDIATRIC PROVIDERS

- Developed by the Family Violence Prevention Fund in partnership with medical associations
- Recommendations for screening and intervention in the pediatric setting
- Available online at www.endabuse.org/health
• Section for service providers includes
  – working with mothers in shelters
  – how abusers parent
  – 10 principles for service delivery

• Section for women includes
  – parenting tips
  – how abuse affects parenting
  – strategies to strengthen the mother/child bond

Baker & Cunningham, 2004
RESOURCE:
SOMETHING MY FATHER WOULD DO

• 16-minute documentary on DVD
• Men talk about growing up with abusive fathers and the choices they made about relationships and parenting
• Includes discussion questions for general audiences and for working with men who batter

endabuse.org
ON-LINE RESOURCES FOR YOUTH

burstingthebubble.com
Informational website for children exposed to IPV

ThatsNotCool.com
Multi-media campaign to educate teens about dating violence
DEFINING SUCCESS

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DEFINING SUCCESS

"Success is measured by our efforts to reduce isolation and to improve options for safety."

Family Violence Prevention Fund
Adverse Childhood Experiences (ACE) Study
Leading Determinants of Health
ADVERSE CHILDHOOD EXPERIENCES STUDY

• One of the largest investigations ever done to examine the links between adverse childhood experiences and later-life health
• Collaborative between the CDC and Kaiser Permanente
• Over 17,000 study participants
• Over 50 scientific publications

www.cdc.gov/nccdphp/ACE
WHAT ARE ADVERSE CHILDHOOD EXPERIENCES (ACEs)?

Experiences that represent health or social problems of national importance. In this study, adverse childhood experiences included:

– Witnessing a mother being battered

– Having a parent who has a substance abuse problem, a history of mental illness, or criminal behavior

Felitti et al, 1998
## PREVALENCE OF ACES

<table>
<thead>
<tr>
<th>HOUSEHOLD EXPOSURES</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>23.5%</td>
</tr>
<tr>
<td>Mental illness</td>
<td>18.8%</td>
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<tr>
<td>Battered mother</td>
<td>12.5%</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>4.9%</td>
</tr>
<tr>
<td>Criminal behavior</td>
<td>3.4%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILDHOOD ABUSE</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>11.0%</td>
</tr>
<tr>
<td>Physical</td>
<td>10.8%</td>
</tr>
<tr>
<td>Sexual</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

Felitti et al, 1998
Ace Study Results

- ACEs are very common and often cluster
- ACEs are strong predictors of health behaviors in adolescence and adult life
- This combination of findings makes ACEs one of the leading, if not the leading determinant of the health and social well-being of our nation
ACEs have a graded relationship with the following diseases:

- Ischemic heart disease
- Cancer
- Chronic lung disease
- Autoimmune diseases
- Skeletal fractures
- Liver diseases
- Premature death

Anda et al, 2009; Dube et al, 2009; Felitti et al, 1998
Persons with 2 or more ACEs were at **100% increased risk** for rheumatic diseases

Dube et al, 2009
• Adults who experienced ACEs had significant and sustained losses in health-related quality of life compared to adults without ACEs

• These findings should be used in assessing cost-effectiveness of interventions to prevent ACEs

Corso et al, 2008
ACEs substantially increase the number of prescriptions and classes of drugs used.

The increases in prescription drug use among adults with ACEs are mediated by ACE-related health and social problems.

Anda et al, 2008
Persons with four or more ACEs had:

4-12 fold increased risk for alcoholism, drug abuse, depression, and suicide attempts

2-4 fold increased risk for smoking, poor self-rated health, having 50 or more sexual intercourse partners, and sexually transmitted diseases
ADVERSE CHILDHOOD EXPERIENCES AND ADOLESCENT ALCOHOL USE

- There is a persistent grade relationship between ACE scores and initiation of alcohol use by age 14
  
  - ACEs account for a 20% to 70% increased likelihood of alcohol use being initiated during mid-adolescence (15-17 years)

Dube et al, 2006
• The number of ACEs increased dramatically for persons who saw their mothers being battered.

• As the frequency of witnessing violence increased, there was a positive, graded risk for:
  - Illicit drug use
  - IV drug use
  - Depression

Dube et al, 2002
MENU
SELECT FROM THE TOPICS BELOW

Overview
Regional and Local Data
Medical Cost Burden and Health Care Utilization for IPV
The Impact of IPV on Women’s Health
IPV and Behavioral Health
IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
IPV and Sexually Transmitted Infections/HIV
IPV and Perinatal Programs
IPV, Breastfeeding, and Nutritional Supplement Programs
IPV and Child and Adolescent Health
ACE Study: Leading Determinants of Health
IPV and Injury Prevention
IPV and Home Visitation

Family Violence Prevention Fund

Linda Chamberlain, PhD MPH
Intimate Partner Violence (IPV) and Injury Prevention
DISCOVERING THE CONNECTIONS

INJURY PREVENTION
- unintentional injury

FAMILY VIOLENCE
- intentional injury

NEUROSCIENCE
- traumatic brain development
- unhealthy coping behaviors
- adolescent risk behaviors
IPV is a leading cause:

- Injuries to women
- Female homicides
- Female suicide attempts

Abbott et al, 1995; Coker et al, 2002; Frye et al, 2001; Goldberg et al, 1984;
Golding et al, 1999; McLeer et al, 1989; Stark et al, 1979;
Stark & Flitcraft, 1995
IPV annual death and injury toll for women:

~1300 deaths
2 million injuries

CDC, 2003
CO-OCCURRING HOMICIDE & SUICIDE

- Over half (58%) of the victims in homicide/suicide incidents are a current or former intimate partner of the perpetrator.

- A substantial proportion (13.7%) of the victims were children of the perpetrator.

Bossarte et al, 2006
PATTERNS OF INJURIES ASSOCIATED WITH IPV:

- Injuries to the head, neck, and face
- Strangulation
- Bites
- Burns and scalding
- Knife wounds
- Injuries from physical restraints

Chirsler & Ferguson, 2006; Grisso et al, 1999; Hawley et al, 2001; Lee et al, 2007; Marchbanks et al, 1990; Smith et al, 2001
Among women reporting injuries resulting from their most recent physical IPV assault:

- **8.5%** brain or spinal cord injuries
- **11.2%** broken bones, burns, or chipped or knocked out teeth
- **6.7%** lacerations, knife wounds, or cuts
- **73.7%** scratches, bruises, welts, swelling, sore muscles, or sprains

Arias & Corso, 2005
More than two-thirds of IPV victims are strangled at least once

{ the average is 5.3 times per victim }
Among women who visit the ER after IPV:

- 67% have symptoms of a head injury
- 30% have suffered loss of consciousness at least once

Chrisler & Ferguson, 2006
26% of parents who brought non-emergent children to the pediatric ED disclosed current IPV

Rhodes et al, 2007
Children exposed to IPV were more likely to live in a home with:

- Gun ownership
- No smoke detectors
- Unsecured poisons
- Inconsistent seatbelt use

Rhodes et al, 2007
High school students disclosing physical and/or sexual violence from dating partners:

17% females
9% males

Ackard et al, 2003
Male and female victims of physical dating violence are more likely to:

- Have their first drink at less than 15 y.o.
- Ride with a drinking driver
- Threaten or hurt someone with a weapon

Champion et al, 2008
IMPLICATIONS FOR INJURY PREVENTION

- Many injury prevention programs do not address IPV as the leading cause of injuries for women.
- Data on IPV as a cause or contributing factor may be overlooked.
- First responders may be the only service providers to observe the scene and interpersonal dynamics of an IPV incident.
STRATEGIES FOR INJURY PREVENTION

- Work with trauma registries and other injury data sources to capture information on IPV
- Integrate information on IPV and violence prevention into childhood injury prevention initiatives
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Educational materials, ongoing training</td>
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<tr>
<td>2</td>
<td>Partner with an advocacy organization</td>
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<tr>
<td>3</td>
<td>Establish policies and protocols</td>
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<tr>
<td>4</td>
<td>Integrate into standardized forms</td>
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<tr>
<td>5</td>
<td>Reimbursement strategies</td>
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</tbody>
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**INJURY PREVENTION: SYSTEM LEVEL RESPONSE**
INJURY PREVENTION:
SYSTEM LEVEL RESPONSE

- Quality assurance & compliance measures
- Facilitate research
- Sponsor conferences, education campaigns
- Promote cross-training
PROMISING PRACTICES: ASSESSMENT

• Questionnaire completed by mothers
• Wide range of questions on child safety including 4 questions on IPV
  • Odds of detecting current IPV increased by 3.6X

Wahl et al, 2004
PROMISING PRACTICES:
IOWA DEPARTMENT OF PUBLIC HEALTH

- Staff position to provide training and technical assistance on IPV to public health staff
- Mandates local health boards to include IPV in their needs assessment and planning
- Added questions on abuse to the BRFSS
- Members of the Iowa Domestic Abuse Death Review Team
- Sponsors train-the-trainer initiative with public health clinics
DEFINING SUCCESS

✓ Safe environment for disclosure
✓ Supportive messages
✓ Educate about the health effects of IPV
✓ Offer strategies to promote safety
✓ Inform about community resources
✓ Create a system-wide response
DEFINING SUCCESS

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Family Violence Prevention Fund
Intimate Partner Violence (IPV) and Home Visitation

This section coming soon!