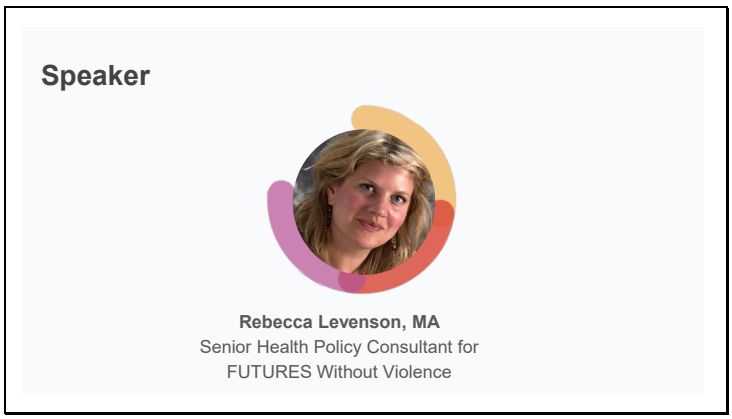
Preventing and Responding to Intimate Partner Violence in Reproductive Health Settings
June 2, 2022
Transcript

Slide 1

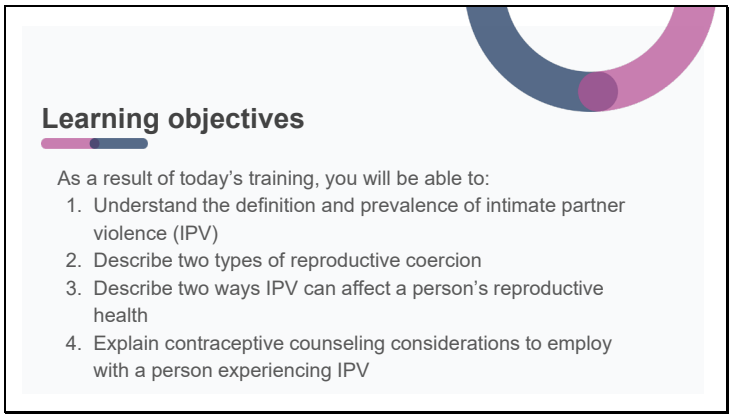
- [Devon] Hello, everyone. Good afternoon. This is Devon Brown from the Title X Reproductive Health National Training Center. And I would like to welcome you all to today's webinar, Preventing and Responding to Intimate Partner Violence in Reproductive Health Settings. I do have a few announcements before we begin today. Everyone on the webinar is muted, given the large number of participants. We do plan to have some time for questions at the end of the webinar today. You can ask your questions using the chat at any time during the webinar. Don't hesitate to put them in there. We'll also be asking for your participation at a few points during the webinar. You can respond in the audience chat pod, which is green and can be found at the bottom of your screen. A recording of today's webinar, along with the slide deck and a transcript, will be available on rhntc.org within the next few days. Closed captioning has been enabled for this webinar. And to view it, you can click on the CC icon at the bottom of your screen. Your feedback is extremely important to us and has enabled the RHNTC to make quality improvements in our work based on your comments. So please take a moment to go ahead and open the evaluation link that's provided in the chat, and consider completing the evaluation real time during the webinar today. In order to obtain a certificate of completion for attending this webinar, you must be logged into rhndc.org when you complete the evaluation. This presentation was supported by the Office of Population Affairs, or OPA, and the Office on Women's Health, or OWH. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA, OWH, or, HHS. So we are really excited to have as our speaker today Rebecca Levenson. Rebecca Levenson has decades of experience helping reproductive healthcare systems respond to intimate partner violence, or IPV. She is a former planned parenthood clinic director and senior health policy consultant for the national nonprofit Futures Without Violence. And she is also a nationally recognized researcher, educator, advocate, and speaker. Rebecca is an author of numerous additional IPV training resources and publications. So with that, I will turn it over to Rebecca.

Slide 2



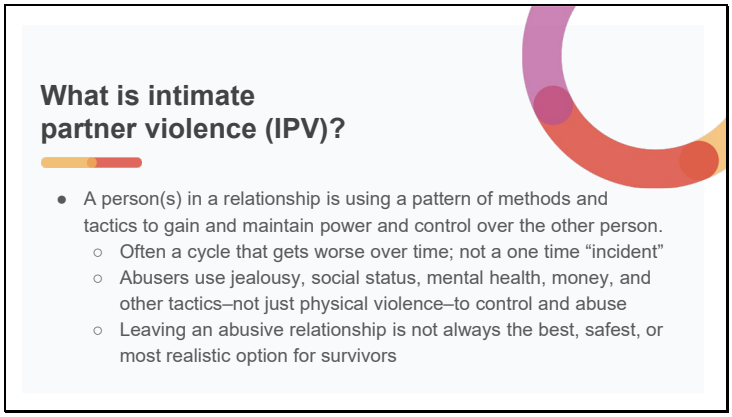
- [Rebecca] Thank you so much, Devon. And hello, my friends from across the country. I'm really excited to be here with you today.

Slide 3



So quickly, I'm going to just do an overview of our learning objectives, right? So we're going to understand the definition and prevalence of IPV. We're going to describe two types of what we call reproductive coercion, and we'll be defining that as well. We're going to describe two ways intimate partner violence can affect people's reproductive health. And we're going to explain contraceptive counseling considerations for folks experiencing IPV.

Slide 4

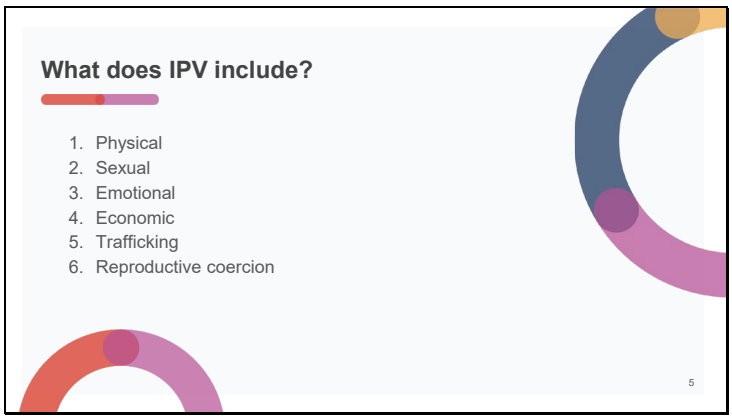


So what is intimate partner violence? And I think one of the things that I really want to push all of you to think about is move beyond sort of our box that we typically put intimate partner violence in, 'cause I think often it's around physical altercations. And for you all today, as reproductive healthcare providers, I want you to be thinking about all the ways in which power and control can impact folks' reproductive and sexual health. So how are we defining it? As a person or people in a relationship using patterns of methods and tactics to gain and maintain power and control over the other. It's often the cycle that gets worse over time. So it's not a one time incident. It's not a one and done. And I think it's also worth noting that what we see is abusers using exactly as much power and control as needed to get the outcomes they want. So for example, I often tell the story about a client that I heard about from Montana, from a Montana provider. And the way power and control showed up for that particular client is that there was a bullet placed on the back of the toilet. And that was enough. There was no direct threat of I'm going to shoot you, or I'm going to kill you, or anything like that. It was just a little bullet on the back of the toilet. And that was enough to scare or intimidate the survivor into doing what the partner wanted. So we see abusers using all kinds of things: jealousy, social status, mental health. So threatening around kids, for example. Like, you're crazy and I'm going to, if you don't do what I want you to do, I'm going to take the kids and nobody's going to give them to you 'cause I can make this case around you being crazy. Access to money. And that's of course something that's going to impact people's ability to get to clinics. So if they don't have money for gas, if they don't have money for transportation, et cetera, that's how power and control can show up. And then I think one of the other pieces I want you to keep in the back of your head throughout the talk today is that leaving an abusive relationship is not the best, safest, or most realistic option for a lot of survivors. And we'll talk a little bit more about that as we move on.

Source:

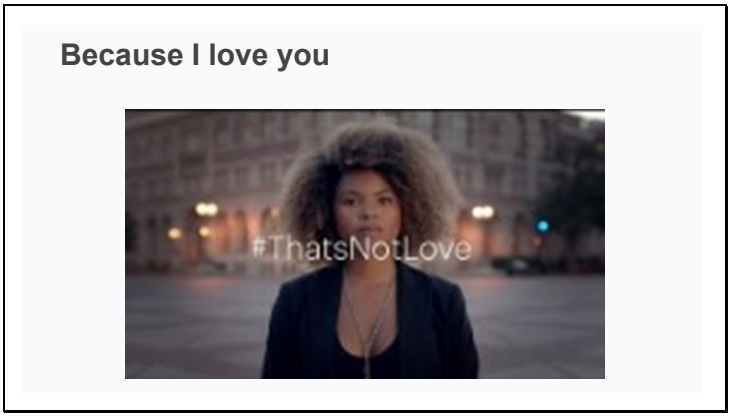
National Domestic Violence Hotline "Understand Relationship Abuse" (https://www.thehotline.org/is-this-abuse/abuse-defined/)

Slide 5



So I mentioned physical violence. That's where people typically think about, right? So choking, other kinds of injuries, but certainly sexual violence is a piece of it. And I know for some of you providers, you've seen this with your clients. Emotional abuse. I will tell you from research I did in Redding, California, around folks who had longstanding abusive relationships with partners and were now out of those abusive relationships, when we asked them the question about of all the things that happened, and of course physical injury was part of it for some of them, what's the thing that stands out most to you, inevitably, the universal response was the words. When someone's told you that you're worthless, that nobody would want you. You're a bad mother. You're a bad person. All the lists. That that's the stuff that absolutely impacts health and wellbeing in those research to support emotional abuse alone impacts reproductive health. I mentioned economic. In COVID, one of the things that we saw was a surge around trafficking. And that includes a partner being the one to require you to have sex for money with someone else. So I think one of the misnomers about trafficking is we often think about as the stranger somewhere over there that's trafficking you from one state to another. But of course, what do we know about trafficking? It's something that happens more often with someone you know, someone in your family, a family friend, or a partner. And we certainly saw an uptick in this in COVID. And then reproductive coercion. When a partner's using pregnancy or contraception access as a means of power and control in a relationship. And we'll be talking more about that later.

Slide 6



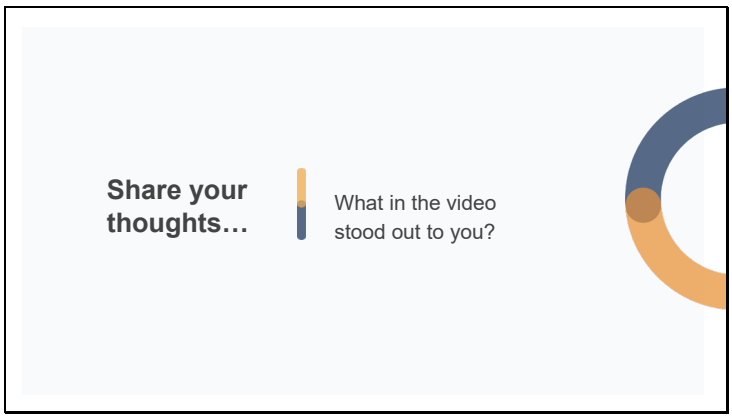
I want to share this video with you. It's short, but I think it really sums up some of the way, other ways power and control shows up in relationships. So I'll go ahead and just play it for you.

- Because I love you, I want to be your only guy.
- Because I love you, skip class with me. Let's stay in bed today.
- Because I love you, I just want to be with you so freaking much.
- Because I love you
- I waited for you after chem lab.
- You were walking with Mark?
- Because I love you
- you shouldn't be hanging out with that dude.
- You should know how dumb that makes me look.
- I don't care that she's your lab partner.
- Why do you have texts from him?
- Because I love you, this number?
- Delete.
- Because I love you, this "Jason" number?
- Delete.
- And Ben?
- Delete.
- Because I love you, I should smash your phone.
- But I'll let you give me your password instead.
- Because I love you
- I will check your texts everyday.
- You got lucky because I love you.
- Because I love you
- you think it's okay
- Because I love you, you understand.
- Because I love you, you stop talking to your classmates.
- And you feel completely alone.
- Because I love you. That's not love.

Source:

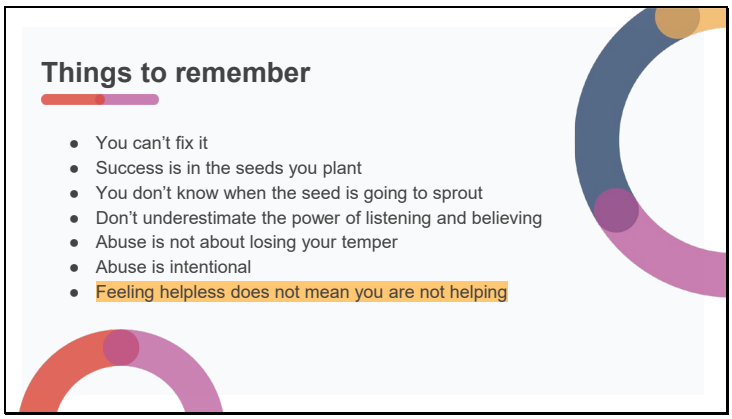
YouTube “#ThatsNotLove campaign | Because I Love You – Delete | One Love Foundation”
(https://www.youtube.com/watch?v=4JYyHa03x-U)

Slide 7



- [Rebecca] Oh. So in the chat, I'd be very interested to hear what stood out for folks, either in the video or what I've covered in the last few minutes as I've been talking about the waste power and control show up in relationships. And I'm going to pull up the chat here. What stood out to you? How it started out kind and sweet, and then progressed to angry. Thank you, Nina. That's great. Other things. Someone checking your texts and messages every day. Video showed aggression. Because I love you. There's a sense of manipulation using emotion and expressing love as a reason to justify it. Manipulation. I realized as a teenager I went through this. Alison, thank you for sharing your story with us. Ashley, it's not always violence. It's the little things like checking the phone. The thing that really got under my skin is the piece around, I'm not going to smash your phone. I just need all your passwords, right? I've noticed an increase in emotional abuse in relationships amongst friends, peers, patients. Gaslighting, manipulation. Not very evident in your face. So this is why, my friends, my reproductive health friends, being able to sort of ask questions, have your radar up, wonder with your clients about how power and control might be showing up for your patients in these ways, because it's so insidious. And especially for our teens, I think it's really difficult. It seems like, oh wow, he really likes me, or she really likes me. And they want to be with me all the time. That's such a compliment, right? And oh, they care so much about me that they don't want to share me with anybody else. And you can see how it begins in one direction and it's really about control. When they started getting mad, they finished with "because I love you" as if it made it better. Thank you. Thank you for all your wisdom. Okay.

Slide 8

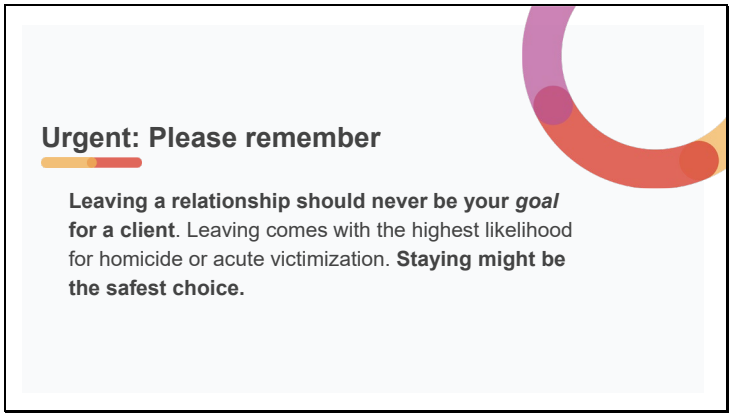


This is wisdom from friends at Domestic Violence Coalitions. This is actually directly from our friends at the Washington State Coalition Against Domestic Violence in Washington State. Things to remember. You can't fix it. Success is in the seeds you plant. You don't know when that seed is going to sprout. Please don't underestimate the power of listening and believing. All of the research tells us that what you say when someone shares their truth with you, when someone shares that they're being hurt, matters a huge amount. So thank you for sharing that with me. I don't even know what to say right now. I'm just so glad you told me. Is something that we want to make sure clinicians feel really clear about how to respond and have that in their back pocket. We don't need you to be an expert, but I think just acknowledging what you've heard and what someone has shared is really the most important thing you can do. Abuse is not about losing your temper. It is completely intentional. And I guess this is the one big piece that really stood out to me as somebody who worked in reproductive health and planned parenthood all those years. It can feel helpless to hear someone's story about how they're being hurt. But feeling helpless does not mean that you're not helping. And I want to say maybe that's worth putting on a sticky note and putting on your computer, or on your mirror, or on your desktop or whatever, but feeling helpless does not mean you're not helping. The fact that you've brought something up or that you were a trusted person that someone shared something with, that was a help, because in their sharing of it, you reduce their isolation. And that is big piece of power and control, is isolating someone from connecting to others. And that's the other reason why clinicians are in a unique position to really help survivors.

Slide 9

So I'm curious to hear, 'cause I know there's a lot of wisdom on this phone, why might a person stay in a relationship when intimate partner violence, power and control has happened? Why do people stay? And you can share with me in the chat. Finances, children, parental threats, nowhere else to go. They claim they will change. Fear of losing kids. Hopefulness. They think they deserve it. Love. Nowhere to go. Fear. Afraid of death. Money, kids, fear. Dependence. They're scared. Fear. Love. Anne, I appreciate you saying love. Culture. I saw that, too. Society pressure. The religious elements certainly can be a part of that. Disappointment. Feelings of worthlessness. If you feel controlled, you are controlled. Failure. Thinking things will get better. Thinking it's normal. You're depressed. Fair. So this is a beautiful list. These are all reasons why people stay. Low self-esteem, low stigma, embarrassment. They don't want people to know. If it's a small community, or if your partner has a lot of, potentially, power in the community, everybody will know what happened. Threats to hurt your children or family is very real as part of power and control. Really good list.

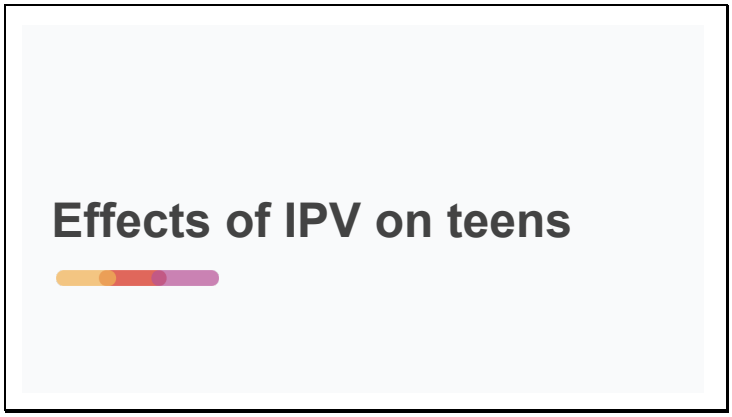
Slide 10



Now, if you remember one thing from my talk today, this is the thing you need to remember. Okay? This is it. As clinicians, leaving a relationship, your client leaving their relationship should never be your goal for the client. Okay? And I think it's so easy as fixers or helpers that we want to make it better, right? And leaving seems like a good way to make it better. Okay. This is why you need to remember this. And remember it in your heart. Leaving comes with the highest likelihood for homicide and acute

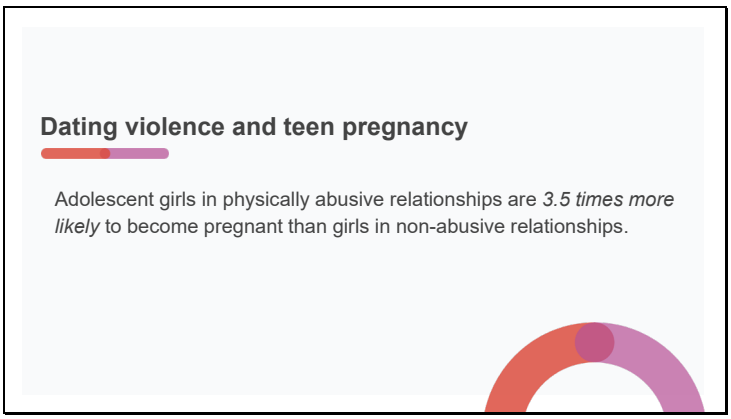
victimization, right? So staying, in fact, might be the very safest choice for that survivor. So this brings us back to what do survivors need from clinicians and other staff who work in Title X clinics and other reproductive health clinics? What they need is for you to listen and let them drive, right? They are the experts in what is going on in their lives. And they are the ones that are going to be able to tell you what's working for them and what they need from you. So the best thing you can do is say, "Thank you for sharing that with me. How can I be of help?" And one of the things I want you to remember in terms of the strategy, we talked about the phone, and I'm going to pick up mine and show you mine, right, what does the abusive person do? They're monitoring every text. They're following what you are looking at on the web. They're monitoring who you called. So offering your phone in clinic is a huge harm reduction strategy because there's no way for the partner to be able to trace what happened on that call. Okay.

Slide 11



So let's talk quickly about the effects of intimate partner violence on teens.

Slide 12



We know that adolescent girls in physically abusive relationships are about 3.5 times more likely to become pregnant than girls who were not in abusive relationships.

Source:

Roberts TA, Auinger MS, Klein JD. (2005). Intimate partner abuse and the reproductive health of sexually active female adolescents. *Journal of Adolescent Health*, 36:380-385.

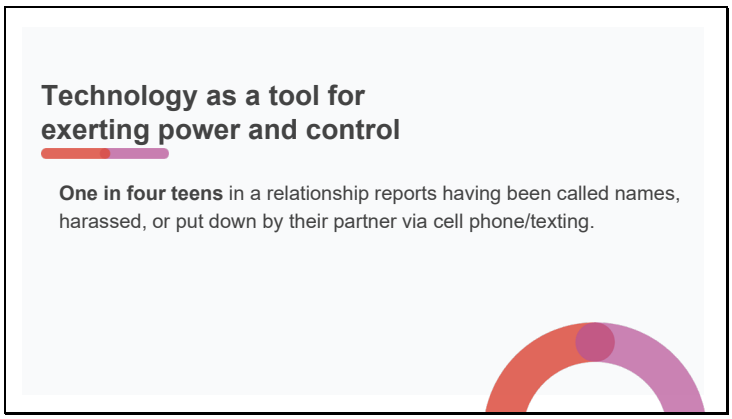
Slide 13

And of course there are things that are tipoffs, right? So we have youth that are depressed and anxious, that have disordered eating, have feelings of suicidality, have substance use issues. Girls in violent relationships are more likely to have those things.

Sources:

- Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. (2009). Dating violence among high school students in southeastern North Carolina. *Journal of School Nursing,* 25(2):141-151.
- Howard DE, Wang MQ, Yan F. (2008). Psychosocial factors associated with reports of physical dating violence victimization among U.S. adolescent males. *Adolescence*, 43(171):449-460.
- Brossard RM, Simon TR, Swahn MH. (2008). Clustering of Adolescent Dating Violence, Peer Violence, and Suicidal Behavior. *Journal of Interpersonal Violence*, 23(6):815 -833.
- Ackard DM & Neumark-Sztainer D. (2002). Date Violence and Date Rape among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health. *Child Abuse & Neglect*, 26(5):455-473.
- Ihongbe, TO. (2017). Age of Sexual Debut and Physical Dating Violence Victimization: Sex Differences Among US High School Students. Journal of School Health, 87(3):200-208. doi: 10.1111/josh.12485.

Slide 14



One in four teens in a relationship reports having been called names, harassed, or put down by their partner via cell phone or texting.

Source:

Zweig, J M, Dank, M, Yahner, J, et al. (2013). The Rate of Cyber Dating Abuse Among Teens and How It Relates to Other Forms of Teen Dating Violence. *Journal of Youth and Adolescence, 42(7): 1063-1077.*

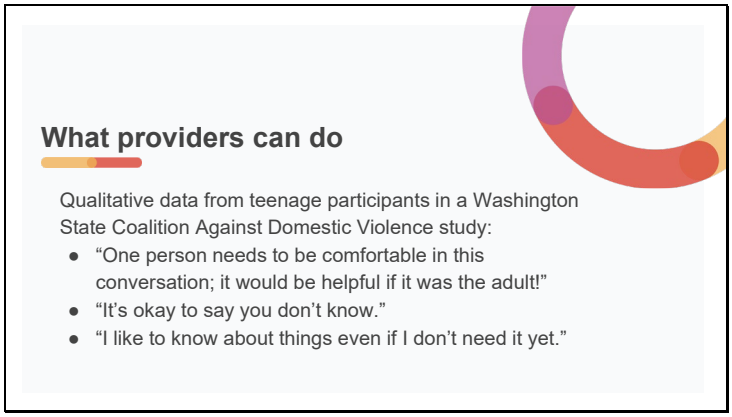
Slide 15

And this is really important because we know that that technological or cyber abuse is connected to both physical abuse and sexual coercion.

Source:

Zweig, J M, Dank, M, Yahner, J, et al. (2013). The Rate of Cyber Dating Abuse Among Teens and How It Relates to Other Forms of Teen Dating Violence. *Journal of Youth and Adolescence, 42(7): 1063-1077.*

Slide 16



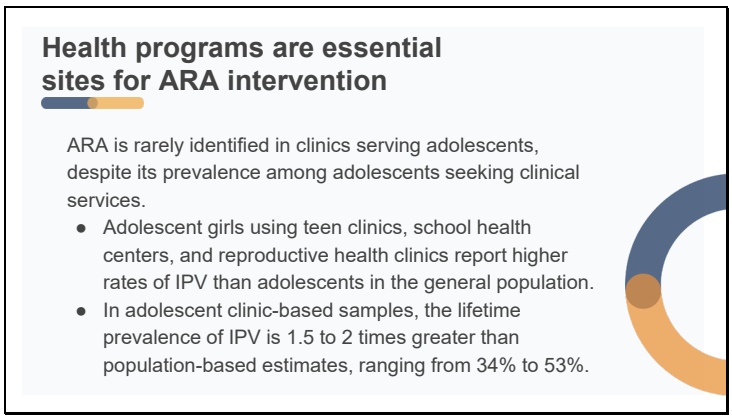
So what can providers do? They can be talking to youth about this. What young people in Washington State told us is one person needs to be comfortable in this conversation about IPV. It would be helpful if it were the adult. They want you to have conversations with them. It's also okay to say you don't know something. And I like to know about things, even if I don't need it yet. So if you're working with younger teens, and they're not yet in a relationship, it's never too early to start planting those seeds.

Sources:

- Washington State Coalition Against Domestic Violence "Talking with Teens about Emergency Contraception & Birth Control" (https://wscadv.org/resources/start-the-conversation-with-teens-about-emergency-contraception-birth-control/)

- Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. Intimate partner violence and health care-seeking patterns among female users of urban adolescent clinics. Maternal Child Health J. 2010;14(6):910-917. doi:10.1007/s10995-009-0520-z

Slide 17

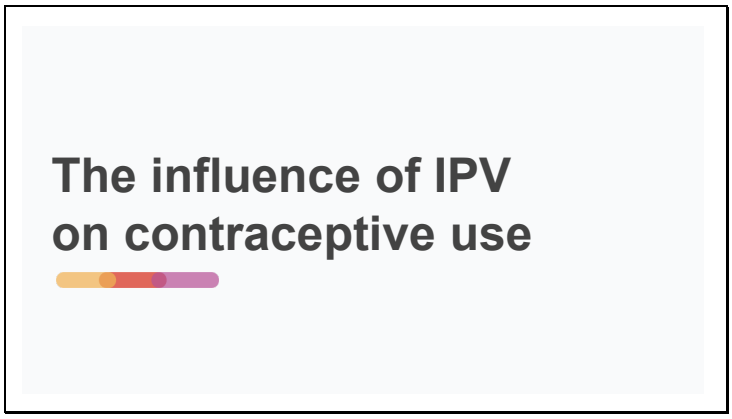


I also think it's worth mentioning that adolescent girls who are using teen clinics and school health centers report higher rates of intimate partner violence than the general population does.

Sources:

- Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. (2010). Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. Maternal and Child Health Journal, 14(6):910-917.
- Ashley OS, Foshee VA. (2005). Adolescent Help-seeking for Dating Violence: Prevalence, Sociodemographic Correlates, and Sources of Help. Journal of Adolescent Health, 36(1):25-31.
- The Commonwealth Fund "The Commonwealth Fund Survey of the Health of Adolescent Girls" (https://www.commonwealthfund.org/publications/fund-reports/1997/nov/commonwealth-fund-survey-health-adolescent-girls)

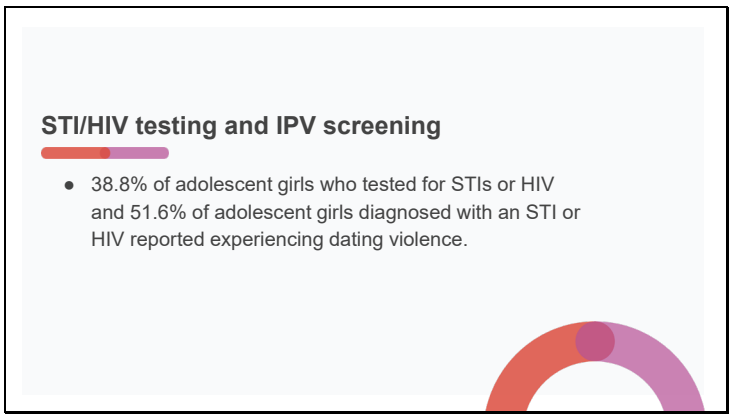
Slide 18



And I want to talk here a little bit more about the influence of IPV and considerations for you all.

Slide 19

Slide 20

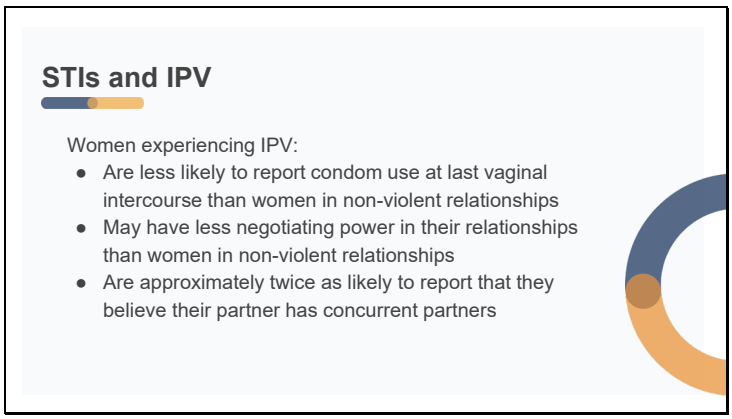


What do we know about STI and HIV testing and screening? We know that 38% of adolescent girls who were tested for STIs and HIV, and 51% of adolescent girls diagnosed with an STI or HIV, were experiencing dating violence. So this tells you that it's a clinical indicator. If you've got a team coming in and saying, "Hey, I need a test for chlamydia," I want to know what's happening in their relationship. And these are the kind of connections that I'm hoping today helps you link up to.

Source:

Decker MR, Silverman JG, Raj A. (2005). Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis Among Adolescent Females. *Pediatrics*, 16(2):3272-276.

Slide 21



Worth also noticing, women experiencing IPV are less likely to report condom use at last vaginal intercourse than women in non-violent relationships. They have less negotiating power in their relationship, which makes a lot of sense. And they're approximately twice as likely to report that their partner has concurrent partners, or that they're at risk for STIs. And yet, at the same time, they feel like they can't negotiate condoms in their relationship.

Sources:

- Hess, K. L., Javanbakht, M., Brown, J. M., Weiss, R. E., Hsu, P., & Gorbach, P. M. (2012). Intimate partner violence and sexually transmitted infections among young adult women. Sexually transmitted diseases, 39(5), 366–371. https://doi.org/10.1097/OLQ.0b013e3182478fa5

- Fanslow J, Whitehead A, Silva M, et al. Contraceptive use and associations with intimate partner violence among a population-based sample of New Zealand women. Aust N Z J Obstet Gynaecol. 2008 Feb;48(1):83–89.

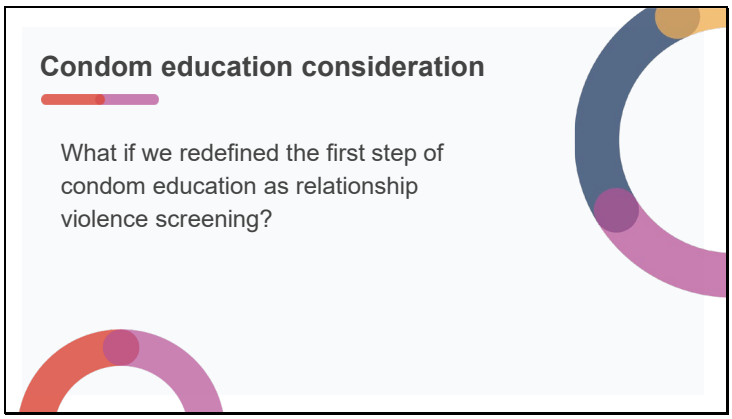
Slide 22

55% of women with HIV have experienced intimate partner violence.

Sources:

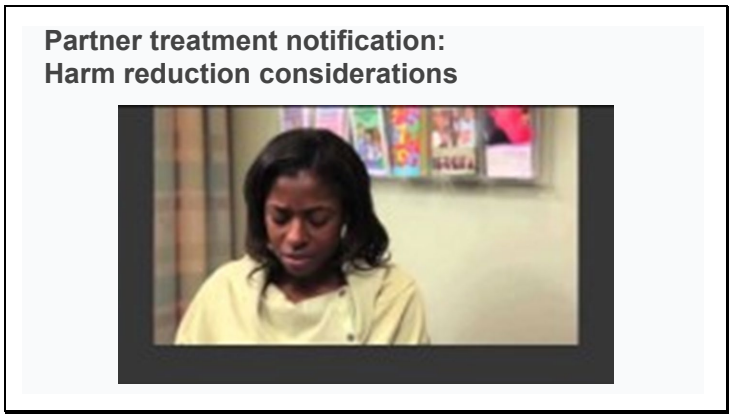
- Maman, S. et al. 2000. The intersections of HIV and violence: Directions for future research and interventions. Social Science & Medicine 50(4):459-478.
- Black MC, et al., (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Machtinger E, et al. (2012a). Psychological trauma and PTSD in HIV-positive women: A meta-analysis. AIDS and Behavior 16(8), 2091-2100
- Black MC, Intimate partner violence and adverse health consequences: implications for clinicians, American Journal of Lifestyle Medicine, 2011, 5(5):428–439.
- Coker AL, Does physical intimate partner violence affect sexual health? A systematic review, Trauma, Violence, & Abuse, 2007, 8(2):149–177.
- Futures Without Violence "HIV Testing, Treatment and Care" (https://www.futureswithoutviolence.org/hiv/)

Slide 23



So I think one of the things I want you all to think about, and this is me going back to my planned parenthood roots, if I had a teen in front of me who had a negative pregnancy test, or who I had just given treatment for chlamydia, I can remember putting extra condoms in that little paper bag, right? Extra lube. Maybe even be funny about how to put on condoms using my hand to show, reminding them all those things. And one of the things that I noticed is some of those perfectly folded paper bags with all those extra condoms were in the garbage. And I want to share that with you because I was making assumptions, and I blew it. I made assumptions that everybody had autonomy, that everybody could talk to their partner about using condoms, and that everybody felt safe talking about condoms. And they don't. And we have to stop assuming that.

Slide 24



So I'm going to share a little video with you. And this is looking at a woman who has chlamydia. And I want you to see what happens with this provider. So I'm going to fast forward just a minute here and play it for you.

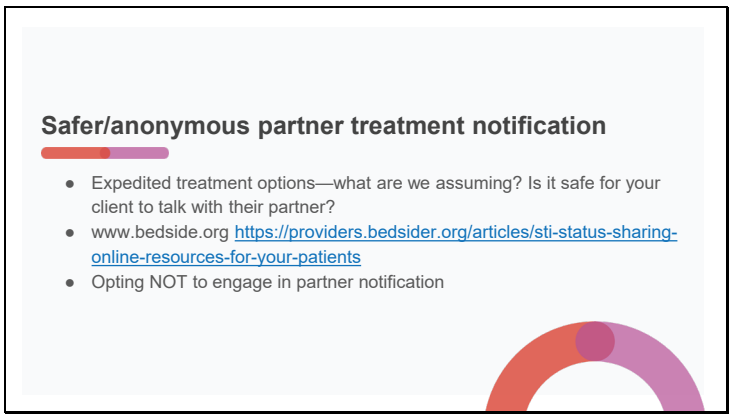
- Jocelyn, what would happen if you told your husband about the infection. If it would help, we could explain all about it here in the clinic. I understand he came into the clinic with you today. Would it help if I talked to him and explained?
- I don't think so. I don't know.

- Another idea is to have the health department call him. They do this kind of thing all the time. They would call him and tell him he's been exposed to chlamydia, but they can't tell him where they got the information from.
- I don't think that's going to help. Jocelyn, are you afraid when he finds out he's going to hurt you?
- He's going to be really, really mad. He's not going to believe I didn't do something.
- Okay. That seems really hard.

Source:

Jocelyn: STI visit (https://www.youtube.com/watch?v=MRUagMrEsu0)

Slide 25

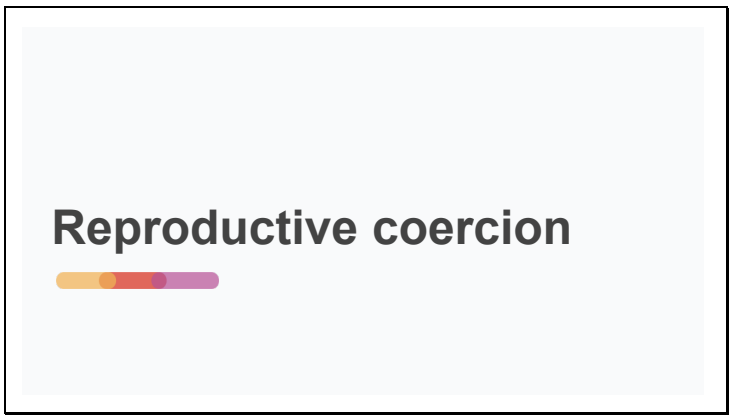


- [Rebecca] And I'm going to stop it right there. And I'm going to ask you, what's coming up for you as you're thinking about my story about the condoms in the garbage or this conversation with the provider here? What's standing out for you about this frame or this video? And you can share in the chat. He's going to think that she cheated. She's terrified. Her emotions. The clinician not picking up on the signals. Scared. Body language. The provider has decided the best answer for the client. Appreciate the, whoa, this is going too fast for me. Hold on one second. Let me just back up for a second. Appreciate the provider asking about possible ways to engage the partner in conversation. She's fearful of his reaction. Absolutely.

Source:

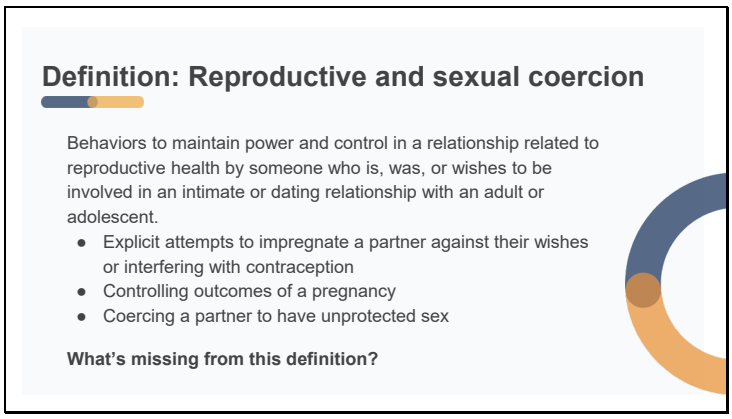
Bedside Providers "STI-status sharing: Online resources for your patients" (https://providers.bedsider.org/articles/sti-status-sharing-online-resources-for-your-patients)

Slide 26



So reproductive coercion, what is it?

Slide 27



It's behaviors to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. And I'm going to say that this definition is about 15 years old now. And I will say that we certainly know that folks are not necessarily in relationships with only one person. So I want to acknowledge that. I also want to acknowledge the issue of trafficking here as well, right? So power and control might not have anything to do with someone who's in an intimate or sexual relationship with you, but somebody who has power and control over who and how and where you have sex, and with whom you have sex, right? And that you have no control over that. So explicit attempts to impregnate a partner or explicit, to impregnate a partner against their wishes or interfering with contraception. Controlling the outcomes of a pregnancy in either direction, whether to carry the term or to have an abortion. Coercing a partner to have unprotected sex. And here, what's missing from the definition would be, of course, trafficking, as I was mentioning before. That this is broader than just what happens with partners. We see reproductive coercion happen in other circumstances.

Sources:

- Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. Contraception, 83: 274-80.

- The American College of Obestricians and Gynecologists "Reproductive and Sexual Coercion Committee Opinion" (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion)

- Futures Without Violence "Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings" (https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf)

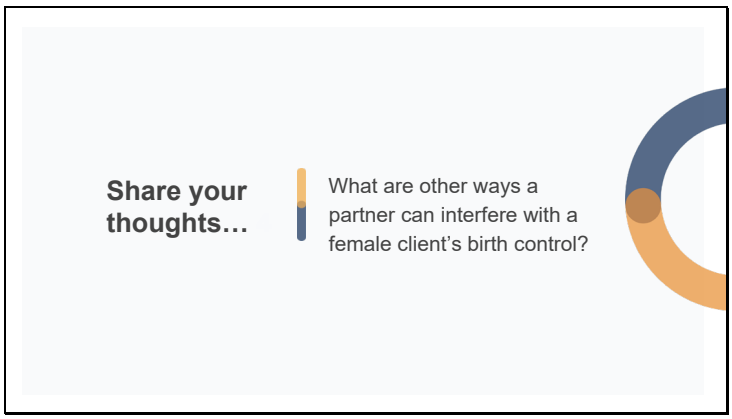
- Youtube Future Without Violence "Making the Connection –Reproductive Coercion" (https://www.youtube.com/watch?v=KRaZl66kLk4&list=PLaS4Etq3IFrWgqgcKstcBwNiP_j8ZoBYK&index=4)

- Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. (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.

- Futures Without Violence "Reproductive & Sexual Health" (http://www.futureswithoutviolence.org/reproductive-sexual-health/)

Slide 28



So what are other ways a partner interferes with birth control? What are you hearing from your patients in the field, or your clients in the field? Oh, I see Nina has a link for us. tellyourpartner.org. Sounds like a safe way to do partner treatment notification. So thank you for that, Nina. What are other ways we see? Thank you. Holes in condoms. Allison, good. What else do you see? We are married. Interesting. Nice. Not allowing IUDs because they will have to feel it during sex. Hiding their pills. Lies. The partner says that they're sterilized. Flushing their pills. Patients who don't want to become pregnant. However, their partner doesn't agree. Removing vaginal ring. Damaging it. Absolutely. Right. Ripping off patches. Trying to remove the next one on at home. Yes, we've seen it. Right. Pulling out IUDs. So what you're describing are the kinds of tactics used. And this may or may not include physical violence. It could just be reproductive coercion that's happening in that relationship. Power and control has really just shown up in that way.

Sources:

- Futures Without Violence "Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings" (https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf)

- Fanslow et al. (2008) conducted interviews with a random sample of 2,790 women who have had sexual intercourse. Women who had experienced domestic violence were more likely to have had partners who refused to use condoms or prevented women from using contraception compared to women who had not experienced domestic violence (5.4% vs. 1.3%).

- Fanslow J, Whitehead A, Silva M, Robinson E. (2008). Contraceptive Use and Associations with Intimate Partner Among a Population-based Sample of New Zealand Women. Australian & New Zealand Journal of Obstetrics & Gynaecology, 48(1):83-89.

- Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. Ambulatory Pediatrics, 7(5):360-366.

- Lang DL, Salazar LF, Wingood GM, DiClemente RJ, Mikhail I. (2007). Associations Between Recent Gender-based Violence and Pregnancy, Sexually Transmitted Infections, Condom Use Practices, and Negotiation of Sexual Practices Among HIV-Positive Women. Journal of Acquired Immune Deficiency Syndromes, 46(2):216-221

Slide 29

So I want to talk a little bit about ACOG's committee opinion on reproductive coercion, which came out in February of 2013. So the American College of Obstetrics and Gynecologists recognized reproductive coercion, and they co-branded guidelines with Futures Without Violence, as well as our intervention. And I think one of the amazing aspects of the work with reproductive health providers is that you all have a unique opportunity to do even more than simply talking about intimate partner violence or making referrals to domestic violence programs because we can be part of helping folks reduce their risk around unintended pregnancy. As we think about that, I want to share a little qualitative data with you that I think really also helps illustrate the story of power and control around reproductive coercion.

Slide 30

Like the first couple of times, the condom seems to break every time. You know what I mean, it was just kind of funny, like, the first six times the condom broke. Six condoms, that's kind of rare. I could understand one, but six times. And then after that, when I got on birth control, he was just like always saying, "You should have my baby, you should have my daughter, you should have my kid." This is a 17-

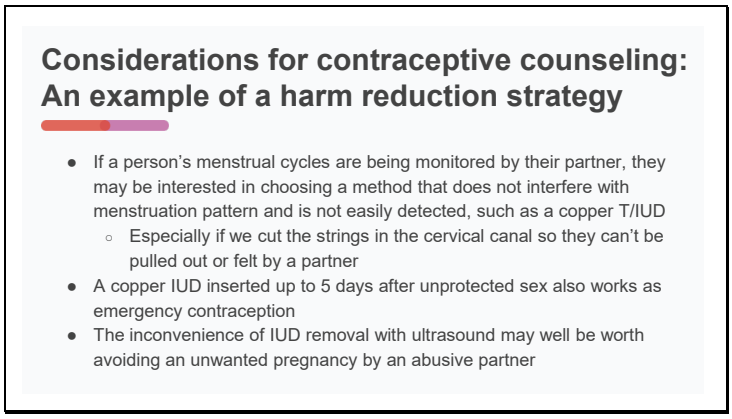
year-old who started Depo-Provera without her partner's knowledge. You know, did the condom break six times, folks? No. Did he want her to get pregnant? Clearly. And we see that in the pregnancy pressure after, right, she got on that birth control. He was like always saying, "You should have my baby, you should have my daughter, you should have my kid."

Sources:

- Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. Ambulatory Pediatrics, 7(5):360-366.

- Findings From a Qualitative Study with Adolescent Females. Ambulatory Pediatrics. 2007;7(5):360-366.

Slide 31



I think the other thing worth mentioning around power and control relative to reproductive coercion, one of the things that we see is that the abusive partner is monitoring menstrual cycles. So they may be interested in choosing a method that does not interfere with their menstrual pattern, right? It's not easily detected, like the copper T/IUD. And what I want to say, and what ACOG supports, and we wrote about in our clinical guidelines that ACOG co-branded with us, is that one of the strategies is inserting a copper T/IUD and actually cutting off the strings when asked, because in that way, the partner can't feel them. And while we know removing an IUD with the strings all the way up in the uterus, or having them cut off, can be a little tricky, and you need an ultrasound, and you need alligator forceps to do that, the power of that intervention for someone who's in this predicament is life changing. Right, we also know that the copper T/IUD can be inserted up to five days after unprotected sex, and it also works as emergency contraception. So I want you to be thinking about this as a strategy, thinking about the prevalence of intimate partner violence and reproductive coercion, that this is a really viable potential answer for some of the folks that you're serving.

Sources:

- Futures Without Violence "Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings"

(https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf)

- Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices (https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices)

- National Library of Medicine "Committee opinion no. 539: adolescents and long-acting reversible contraception: implants and intrauterine devices" (https://pubmed.ncbi.nlm.nih.gov/22996129/)

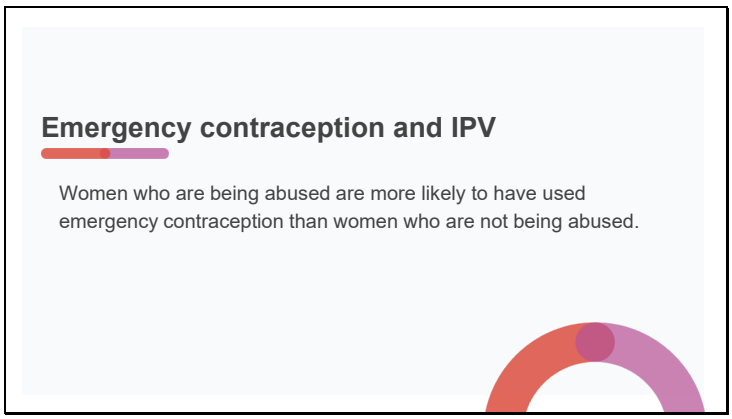
Slide 32

I also want to mention that this is not something that just happens to folks that aren't in marriages. It happens to folks who are in marriages. The odds of experiencing interference with attempts to avoid pregnancy was 2.4 times higher among women disclosing a history of physical violence by their husbands compared to women not experiencing abuse.

Source:

Clark CJ, Silverman J, Khalaf IA, Ra'ad BA, Sha'ar SA, Abu Al Ata A, Batieha A. (2008). Intimate partner violence and interference with women's efforts to avoid pregnancy in Jordan. *Studies in Family Planning*, 39(2):123-132.

Slide 33

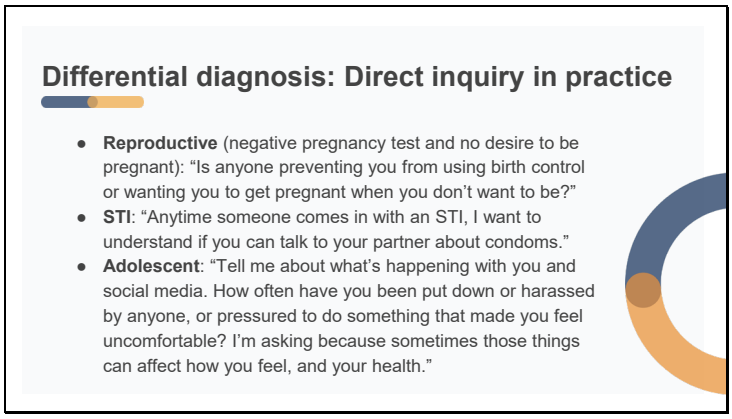


Right? Women who are being abused are more likely to have used emergency contraception than women who are not being abused. This makes a lot of sense in the context of, right, not being able to negotiate condoms, or a partner saying, "I'm going to pull out," and they don't do that because they want you to get pregnant. So I want you to be thinking about is the need for emergency contraception maybe a tipoff that she's not able to control her reproductive health with her partner.

Sources:

- Lewis, N. V., Moore, T., Feder, G. S., Macleod, J., & Whiting, P. (2018). Use of emergency contraception among women with experience of domestic violence and abuse: a systematic review. BMC women's health, 18(1), 156. https://doi.org/10.1186/s12905-018-0652-7
- Rebekah E. Gee, MD, MS, MPH, Nandita Mitra, PhD, Fei Wan, MS, Diana E. Chavkin, MD, Judith A. Long, MD. Power over parity: intimate partner violence and issues of fertility control .Am J Obstet Gynecol 2009;201:148.e1-7.

Slide 34



So certainly I want to say that there are places, if you have that little tickle in the back of your head, you can ask very direct questions related to the visit type. Is anyone preventing you from using birth control

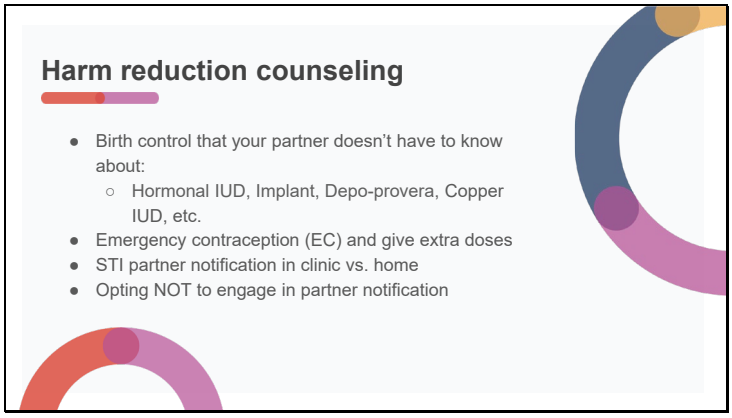
or wanting you to get pregnant when you don't want to be? That's a question I would ask with a negative pregnancy test. Anytime someone comes in with an STI, I want to understand if you can talk to your partner about condoms. If you can talk to them about partner treatment notification. Tell me about what's happening with you and social media. And this is really, I think, so important for adolescents. How often have you been put down or harassed, pressured to do something that made you feel uncomfortable? I'm asking 'cause those things can affect how you feel, and your health.

Sources:

- Elizabeth Miller, Heather L. McCauley, Michele R. Decker, Rebecca Levenson, Sarah Zelazny, Kelley A. Jones, Heather Anderson, and Jay G. Silverman, Implementation of a Family Planning Clinic–Based Partner Violence and Reproductive Coercion Intervention: Provider and Patient Perspectives Respect Sex Reprod Health. 2017 Jun;49(2):85-93

- Mary Ann Lielert Inc. Publishers "The Controversy on Screening for Intimate Partner Violence: A Question of Semantics?" (https://www.liebertpub.com/doi/abs/10.1089/jwh.2008.1252)

Slide 35



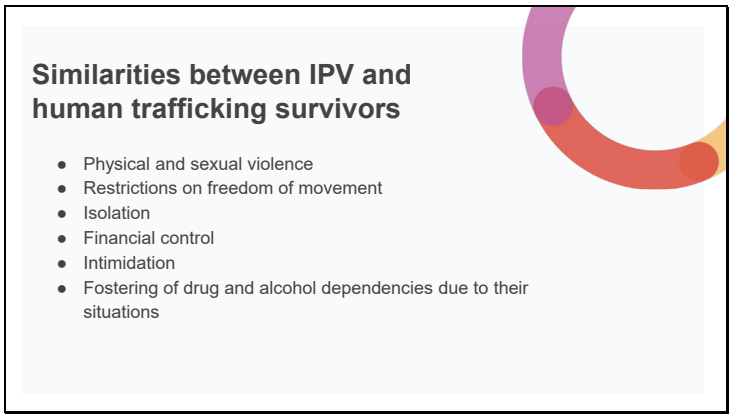
So we talked a little bit about harm reduction strategies. And I'm doing a quick time check. So we talked about the copper TIU/D. And certainly, there are other methods, like Depo-Provera, implants, hormonal IUDs that would be difficult, potentially, for a partner to mess with. But if we're really worried about a partner who's following that menstrual cycle, the copper T/IUD or emergency contraception, I think, is a really good option. One of the other things that we know is when EC comes in that box, or Ella comes in a particular, anything that's branded, it's pretty obvious about what it is. And so one of the harm reduction strategies is you take out those pills and you put them in an empty Advil bottle or some other way. And that's a another harm reduction strategy that clinicians can be sharing with survivors of reproductive coercion.

Sources:

- Rebekah E. Gee, MD, MS, MPH, Nandita Mitra, PhD, Fei Wan, MS, Diana E. Chavkin, MD, Judith A. Long, MD. Power over parity: intimate partner violence and issues of fertility control .Am J Obstet Gynecol 2009;201:148.e1-7.

- Futures Without Violence "Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings" (https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf)

Slide 36



I know we're not talking specifically about trafficking today, but it is always on my heart because I know this is a part of intimate partner violence. It's not just this thing that happens over here. And the way power and control shows up around trafficking, it's very similar to intimate partner violence, right? So there might be physical and sexual violence, restrictions on freedom, isolation, financial control, intimidation, fostering drug and alcohol dependencies due to their situations. And that's actually true in intimate partner violence as well.

Slide 37

And I think it's also worth noting that, again, your role for survivors of trafficking is really important because we see that a 2014 study revealed that 88% of participants identifying as sex trafficking survivors had come into contact with healthcare while they were being exploited. And again, we have real opportunities here in the way that we think about that differential diagnosis, the way we bring questions and conversations about power and control into the center of the room with the folks that we serve.

Sources:

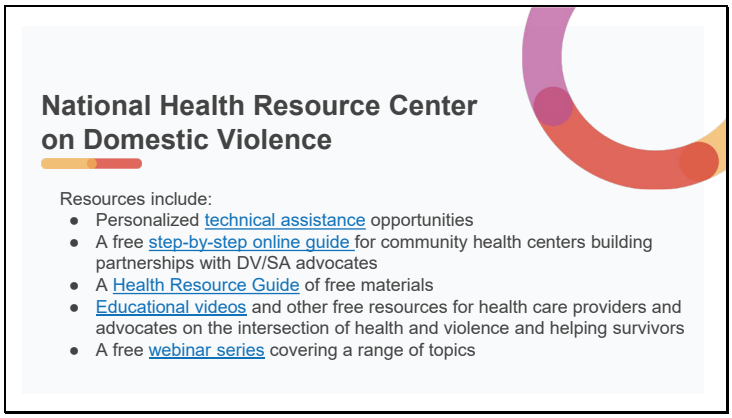
- Laura J. Lederer* and Christopher A. Wetzel, The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities, Annals of Health Law Volume 23, Issue 1 (Winter, 2014)

- Loyola University Chicago School of Law "Annals of Health Law" (https://www.globalcenturion.org/wp-content/uploads/2014/08/The-Health-Consequences-of-Sex-Trafficking.pdf)

- The Reproductive National Health Training Center "Responding to Human Trafficking in the Title X Context Toolkit" (https://rhntc.org/resources/responding-human-trafficking-title-x-context-toolkit)

- The Reproductive National Health Training Center "Identifying and Responding to Human Trafficking in Title X Settings eLearning Course" (https://rhntc.org/resources/identifying-and-responding-human-trafficking-title-x-settings-elearning-course)

Slide 38



So if you're interested in more things here, more on these topics, there's ongoing technical assistance available to you through Futures Without Violence, or the National Health Resource Center, as I mentioned before. So we have step-by-step online guides. We have a health resource guide. We have educational videos. You got to see one of them today. One of 28 videos that we have about how power and control is showing up in specific healthcare instances. So there's one on emergency contraception. There's one on a pregnancy test. There's just lots of options there. And we, of course, also have additional webinars for you all to tap into.

Additional resources:

- IPV Health (https://ipvhealth.org/)

- IPV Health "Health centers are key to violence prevention" (IPVHealthPartners.org)

- Futures Without Violence "Online Store" (https://store.futureswithoutviolence.org/)

- Futures Without Violence "National Health Resource Center on Domestic Violence" (https://www.futureswithoutviolence.org/health/national-health-resource-center-on-domestic-violence/)
- Futures Without Violence "Health Resource Guide: Key Tools" (https://www.futureswithoutviolence.org/wp-content/uploads/2019-Health-Resource-Center-on-DV-Guide-FINAL.pdf)
- Futures Without Violence "Educational Videos for Health Care Providers and Advocates" (http://www.futureswithoutviolence.org/health-training-vignettes/)
- Futures Without Violence "Webinars" (https://www.futureswithoutviolence.org/resources-events/webinars-3/)

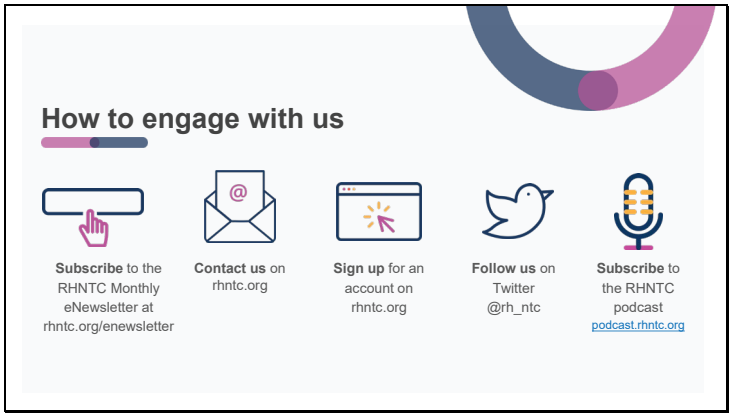
Slide 39

So I'll stop there. And before we get into the Q and A, I just want to know, because I have a couple of, I have an extra minute, so I want to pick your brain, what stood out for you today in this talk? Is there anything that's bubbling to the surface for you that's like an aha, I'm going to take this thing home with me? I'd love to hear from you in the chat. Is there anything that kind of stood out for you, especially? Feeling helpless does not mean you're not helping. I really liked the partner treatment notification study or conversation. How to ask questions related to their visit. The goal isn't to get them to leave. Paying attention to the stories you hear. Thank you for that. Letting patients use our phone so their partner can't track it. Please, please, please know that's so important. We've heard it over and over and over again. An STI can indicate IPV, as can a pregnancy test. Thinking about IPV and partner treatment notification and how that might be triggering. Paying attention to signals. In many ways, IPV can exhibit itself and it's not just physical. Thank you. Do not try to remove persons, even if they're not safe. Beautiful, Roxanne. That was the most important thing I asked you to take away with you today. So thank you for that. So I'll stop here now. And Devon, if there's more in the chat, I'm going to stop looking at the chat and I'm just going to be present. Were there questions that came through during the talk? Do you have something to kick me off with?
- [Devon] Yes.
- [Rebecca] Okay.

- [Devon] Yes, Rebecca. We have a couple. So the first one that came up, you said that leaving should not be our goal, but what do you mean by that? Don't we want them to be safe and be in a healthy relationship?
- [Rebecca] We do. We want them to be safe. We want them to be in a healthy relationship, but we also don't want to increase harm. And so this piece around we know that leaving comes with the highest likelihood of homicide, extreme violence. We need to pay attention to that data point, right? And this goes back to me saying you've got to let the client drive. Sometimes people do want help leaving a relationship. So I'm not saying it's never the case that someone doesn't want to do that. But you as a clinician don't want to pressure them in that direction because I believe the client is the expert in their lives. And I think that this really lends itself to thinking about partnering with local domestic violence advocacy services so they can help you think about safer planning strategies, or you can do a warm referral to them so that they can get more support for that. But I think that there's this knee-jerk reaction to, oh, you've got to leave. And that's what I'm wanting us to all stop. I want us to all pay attention and notice that that actually could increase harm, as opposed to helping in the way that we want to help. But yes, of course, we want everyone to be in a healthy and safe relationship. And the next webinar we do is going to be about universal education specifically around what people deserve in relationships, and what they can do to get help in complicated relationships. So it's a perfect question.
- [Devon] Yeah. The next one, are there any good resources out there for teaching negotiation skills specifically for teenagers?
- [Rebecca] Mm, that is a really good question. And yes, there are some tools. I'm actually thinking about our friends in school-based health settings. We've done a lot of work with them over the last several years, and I know that there are some resources there. And I don't have them on the tip of my tongue, but I can forward them to you, Devon, and you can share them out after this.
- [Devon] Okay. That'd be great. Thank you. The next one, let's see, when you call a client and the partner will not let you talk to the client, what's the best thing to do, if they're not keeping appointments, they're not giving... I may be messing up this question. So whoever asked this, if you want to re-ask it after I'm finished, feel free to put it in the chat again. So let me just try again, Rebecca, so it's clear. When you call the client and the partner will not let you talk to the client, what's the best thing to do?
- [Rebecca] So here's what I want to empower you all to think about. That is, changing your signage in your clinic to say, "We always see clients alone at some point in the visit." And that has to be a standard practice for exactly that reason, because I don't want you to have to go toe to toe with partner who's aggressive, right? And say no, or you now have to get into it. I think it's really much easier if there's a sign and it's normalized. This is what we do with everybody. I think in an extreme situation, if you feel like that, we've done things like bring clients to the bathroom for a clean catch urine sample, and we've had conversations with them about what's going on in their relationship in that way. And so that's another option, is sort of a part of the clinical exam, or what have you, that we need to do this weight, or some other kind of lab situation so that it's too small to have two people in that room. But I do think, overall, right, just from a HIPAA perspective and from a safety perspective, we want to make sure, even with teens who I know can be like stoned together at the arm, then they have to go with their friends, we really want to see them alone because we don't know if it's a friend or a family member, if they might be in collusion with the abusive partner, or being asked to take tabs, or pay attention to what the provider's saying. We don't know what the role of that other person is, right? So the only way we can ensure that we can have a real conversation that is based in safety is to have that person do this alone. And I think you all deserve, as clinicians, to have that up on the wall in great big letters so that you're not having, or your medical assistant, or your receptionist is not having to go toe to toe with anybody, because it should be the standard of practice. And especially with intimate partner violence.

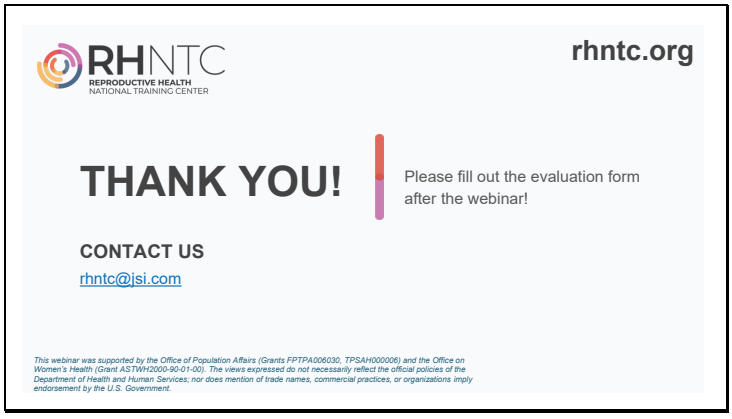
- [Devon] Would you just repeat what that phrase should be that you're suggesting they put in the waiting room?
- [Rebecca] Yeah, so we always see patients alone at some point in their visit, or the first part of their visit, or however you want it to, but we always see patients alone for some portion of their visit. And, in all fairness, I would say to you, like one of the things that we want is for survivors of sexual assault to have a friend in the room to be with them, if that makes them feel more comfortable, right? And you can describe like, "Hey, we always pull everybody aside," to that client, "because we want to understand if there's anything that's really hard happening in your relationship," et cetera, et cetera. And then of course acknowledging. And if you have somebody here that you want to have in the exam room, you are totally welcome to have them in there for the visit, right? So those are my thoughts there.
- [Devon] Thank you. And then I think we just have one more question. By not offering EPT, it kind of feels like we're giving up on them. I think "them" being the client, perhaps. Can you help me understand how this is not offering inferior care?
- [Rebecca] Ooh, great question. So, first of all, I want you to offer expedited partner treatment. I just want you to know that that's something the client can do, right? So before you assume it and hand it to them and say, "Please treat your partner," I want you to say, "Hey, we have this really cool thing called expedited partner treatment, and we can treat your partner, but I always check in first to know, I want to know from you, are you going to be able to talk to your partner about this? Is it safe for you to do that? Can you talk about condoms with them?" So it's not that I'm saying no expedited partner treatment. Please. I did something wrong, if that's what people are coming away with. I love expedited partner treatment, right? Yes, yes, yes. But for the number of times I had somebody come in with chlamydia over and over and over again, if you don't think I'm not kicking myself because they didn't give that brown paper bag to that partner. They weren't able to. You know what I mean?
- Yeah.
- So that's what I'm wanting you to be thinking about.
- And it just goes-
- Got some cleared. Devon.
- [Devon] It did seem totally clear. And it goes back to, I think, a big message of what you're saying today, which is let the client drive-
- [Rebecca] Let the client drive.
- [Devon] and really listen to, what, give them a chance to share their experience and direct what comes next, what comes after that. So I think we are coming up to the end of the hour, so I'm going to move us into our wrap-up. Thank you all for your questions. We will give you another opportunity to submit additional questions, if there's anything else you wanted to ask and we didn't get to in our last few minutes. So to kind of move us into the end, thank you all so much for joining us today. And I hope that you will join me in thanking our wonderful speaker, Rebecca. As a reminder, we will have the materials from today's session available on our website within the next few days.

Slide 40



To stay in touch with the RHNTC, you can subscribe to our monthly eNewsletter by visiting rhntc.org/enewsletter. And Rebecca, will you just move us to the next slide? Sorry. So folks can see the ways to get in contact. So you can subscribe to our monthly eNewsletter by visiting rhntc.org/enewsletter. You can contact us through our website. That's rhntc.org. You can sign up for an account on our website. You can follow us on Twitter. Find us @rh_ntc. And then, finally, you can subscribe to our podcast through podcast.rhntc.org, or in your favorite podcast app. If you have any additional questions for the RHNTC on this topic, please don't hesitate to email us at rhntc@jsi.com. And our final ask is that you please complete the evaluation today. The link to the evaluation is in the chat, and it will appear also when you leave the webinar. And it will be emailed to you after the webinar. So lots of ways to op opportunities to give us feedback. We really love hearing from you, and we use it to inform future sessions. And again, just a reminder, in order to obtain a certificate of completion for attending this webinar, you must be logged into rhntc.org when you complete the evaluation. So thank you again so much for joining us today, and that concludes this afternoon's webinar.

Slide 41



Email us at rhntc@jsi.com.