A Trauma-Informed Model of Care for Assessment and Intervention for Victims of Intimate Partner Violence

August 25, 2016

Noga Zerubavel, Ph.D.
Director, Stress Trauma and Recovery Treatment Clinic
Cognitive Behavioral Research & Treatment Program
Dept. of Psychiatry & Behavioral Sciences
Duke University Medical Center

Break the silence.
Patient handouts and other resources available by email

noga.zerubavel@duke.edu

Stress Trauma and Recovery Treatment
(START) Clinic
Defining IPV

- Systematic pattern of controlling, dominating, or coercive behavior used to achieve broader effect of power and control.

- Fear, intimidation, & humiliation are used to control one person in an intimate relationship.

- Contrast to violence as a result of poor emotion regulation (e.g., anger dysregulation).
Types of abuse

- Physical
- Sexual
- Psychological
  - Intimidation; threats; destruction of keepsakes, property, or personal possessions; humiliation and systematic degradation
- Economic
- Social isolation
- Abuse of others or threats of abuse of others
  - Children, animals/pets
Who has these experiences?

- Perpetrator and/or victim may be male, female, transgender, queer identity
- May be married, separated, divorced, or single
- May be of any sexual orientation, race, ethnicity, socio-economic status, educational background, or age
- May currently live together, may have lived together in the past, or may have never cohabitated
Notes on terminology

- Domestic Violence (DV) ⇒ Intimate Partner Violence (IPV)
  - Gender neutrality
  - Inclusive of same-sex relationships
  - Inclusive regardless of marital status
  - Distinguishes between dynamics of intimate partnership and child abuse/elder abuse

- “Victim” and “Survivor”
BASIC FACTS ABOUT IPV
Lifetime prevalence (in the United States)

- Women
  - > 1 in 3 women (35.6%; ~42.4 million) have experienced rape, physical violence, and/or stalking by an intimate partner.
  - 1/3 women (32.9%) has experienced physical violence by an intimate partner.
  - Nearly 1 in 10 women (9.4%) has been raped by an intimate partner.

- Men
  - > 1 in 4 men (28.5%; ~32.3 million) have experienced rape, physical violence, and/or stalking by an intimate partner.
  - Most of the violence reported by men is physical violence.

Data from The National Intimate Partner and Sexual Violence Survey’s 2010 Summary Report (Black et al., 2011)
North Carolina IPV Homicides

Number of Domestic Violence Related Homicides, 2010-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>DV Homicides</td>
<td>107</td>
<td>106</td>
<td>122</td>
<td>108</td>
<td>119</td>
<td>99</td>
</tr>
</tbody>
</table>

Gender Percentages for Reported Data (2015)

Offender count may differ from victim count, because single victims may have more than one offender and one offender might have multiple victims.

(North Carolina Department of Justice, 2016)
24-hr Domestic Violence Census Survey

- 9/16/15 – collect data over 24 hours
- 1,752 out of 1,894 (93%) of DV programs in U.S.
- **71,828** victims served in one day (adults + children)
  - 40,302 took refuge in emergency shelters or transitional housing provided by local DV programs
  - 31,526 received non-residential assistance and services, including counseling, legal advocacy, and children’s support groups

(National Census of Domestic Violence Services, 2015)
Health effects of IPV

- Post-traumatic stress disorder (PTSD), anxiety, depression, suicidal ideation, sleep disorders, alcohol and substance use disorders
- Physical trauma or injury
- Chronic pain, gastrointestinal disorders, and neurological problems, perceived poor general health
- Gynecological problems, unwanted pregnancy
- Increased rates of health care utilization

(Campbell, 2002; Crofford, 2007; Leserman & Drossman, 2007; Hathaway et al., 2000)
What do medical providers need to know about IPV?

**US Preventive Services Task Force has made the recommendation that medical providers screen for IPV**

- **Recommendation:** clinicians should screen all women of childbearing age for IPV, and provide or refer women who screen positive to intervention services.
- Applies also to women who do not have signs or symptoms of abuse.

(Moyer on behalf of the U.S. Preventive Services Task Force, 2013)
POWER AND CONTROL
Understanding the dynamics of IPV: Development of IPV relationships

- Often high levels of commitment are elicited rapidly
- Traits such as jealousy and hypersensitivity may be interpreted as indicative of how special this love is
- Abuse may appear to be situation-specific
- Abuse may escalate gradually; the boundary moves in increments as the victim accommodates a bit more at any given time
Understanding the dynamics of IPV: Cycle of abuse

Honeymoon

Contrition

Building Tension

Eruption

IPV victims leave abusers an average of 7 times
(National Coalition Against Domestic Violence, 1994)

(Walker, 1979)
During contrition phase, abusive partners shower victims with exceptional affection and expressions of devotion.

Victims long for the intensity of connection during contrition.

“No ordinary love could have this sort of intensity” (Herman, 1992)
Understanding the dynamics of IPV: Behavioral learning principles

- **Traumatic bonding** – intermittent alternating of aversive arousal (i.e., punishment) and relief (i.e., reinforcement) by abusive partners

- Experimental paradigms in learning theory highlight that intermittent reinforcement is particularly challenging to extinguish

(Dutton & Painter, 1993)
Revictimization in Adulthood

• Nationally representative study (8,000 women)
  • CSA victims 3 times more likely to have physical IPV in their current relationship than nonvictims
  • CSA victims 6 times more likely to have sexual IPV in their current relationship than nonvictims

(Desai et al., 2002)
Why do victims stay in abusive relationships?

- Love and attachment
- Belief that the situation is temporary
- Self-blame
- Shame
- Fear – of abuser & of system
  - Leaving can be extremely dangerous
- Does not perceive the behavior as abuse
- Belief that all relationships are violent
- Lack of personal support
- Lack of awareness of community resources
- Dependence – financial, housing, parenting
- Known and familiar
TRAUMA-INFORMED MODEL OF CARE
Core Values of Trauma-Informed Care

Safety
Trustworthiness
Choice
Collaboration
Empowerment

(Harris & Fallot, 2001)
Elements of Trauma-Informed Systems of Care

- Early screening and comprehensive assessment of trauma
- Consumer driven care and services
- Trauma-informed, educated and responsive workforce
- Provision of trauma-informed, evidence-based and emerging best practices
- Create safe and secure environments
- Engage in community outreach and partnership building
- Ongoing performance improvement and evaluation
ESCALATING DANGER

Violating Confidentiality...
Interviewing in front of family. Telling colleagues issues discussed in confidence without her consent. Calling law enforcement without her consent.

Trivializing & Minimizing Abuse...
Not taking the danger she feels seriously. Expecting tolerance due to the number of years in the relationship or recent illness.

Normalizing Victimization...
Failing to respond to her disclosure of abuse. Acceptance of intimidation as normal in relationships. Belief that abuse is the outcome of non-compliance with patriarchy.

Blaming the Victim...
Asking what she did to provoke the abuse. Focusing on her as the problem “why don’t you just leave? why do you put up with it? why do you let him do that to you?”

Ignoring Her Need for Safety...
Failing to recognize her sense of danger. Being unwilling to ask “is it safe to go home? do you have a place to go if the situation escalates?”

Not Respecting Her Autonomy...
“Prescribing” divorce, sedative medicines, going to a shelter, couples counseling, or law enforcement involvement. Punishing the client for not taking your advice.

Mental Health System
Power & Control

INCREASED ENTRAPMENT
BEST PRACTICES FOR PSYCHIATRIC CARE FOR IPV VICTIMS
Philosophy of intervention for IPV

- **Empowerment** – honor the patient’s decisions
  - Victim may not want to leave the abusive partner
  - Exception: limits of confidentiality

- **Collaborative** – balance of power and control
  - Non-directive regarding intervention targets or modalities
  - Directive regarding implementation of intervention and effective use of the therapy hour

- **Offer options and resources**

- **Express understanding of complexity of IPV relationships**
When do victims ask for help?

Honeymoon

Contrition

Building Tension

Eruption
Elements of psychiatric treatment

- Assessment
- Safety planning and risk assessment
- Development & refinement of treatment goals
- Psychoeducation
- Stabilization and coping with symptoms
- Addressing traumatic experiences
- Building resources
- Re-evaluating goals

Triage:
- Crisis response
- Safety planning
Important safety considerations

- Does the abuser know the patient has these appointments?
  - Appointment calls or emails

- Electronic Medical Record
  - Problem list is visible

- Discussion with patients regarding handouts and paperwork
INITIAL EVALUATION AND ONGOING DURING TREATMENT

ASSESSMENT OF IPV
Screening for IPV: It is imperative to ask

- Patients may not speak of it without being asked
  - Taboo – societal, cultural, and media messages that tolerate or promote negative stereotypes of abused individuals based on gender, race, or social class
  - Patients may worry providers do not know about or understand IPV, may not believe them, may assign blame to a patient disclosing abuse, or may demand a particular outcome

- Screen for IPV privately - if someone has accompanied the patient, request time alone

- Assess for all types of IPV: verbal, psychological, isolation, financial, sexual, and physical abuse
There is no evidence of harm from screening for IPV

- **Family medicine**: randomized controlled trial of 6,500 family medicine patients in Canada
  - No harm, but did not find benefit
  - Design problems including attrition

- **Emergency room**: 2,134 participants in a relationship in the last year were screened
  - 548 (25.7%) screened positive for IPV
  - No evidence of violence resulting from screening process
  - 35% (n=131) reported contacting community resources during 3-month follow-up period

(Houry et al., 2008; MacMillan et al., 2007)
Screening and assessments should **not** occur if:

- There is no way to conduct the assessment in private
- There are concerns that assessing the patient would place the patient or provider at risk
- There is a language barrier and the provider is unable to secure an appropriate interpreter

(Haber & Roos, 1985)
Partner Violence Scale

Scoring: Positive response to any question

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?
   ☐ Yes ☐ No
   If so, by whom?
   ☐ Person in current relationship
   ☐ Person from previous relationship ☐ Someone else

2. Do you feel safe in your current relationship?
   ☐ Yes ☐ No

3. Is there a partner from a previous relationship who is making you feel unsafe now?
   ☐ Yes ☐ No

(Feldhaus, Koziol-McLain, Amsbury, Lowenstein, & Abbott, 1997)
Assessing Relationships

- Volatile relationships are 2-sided; IPV is 1-sided
- IPV is not an argument or a fight – one person is afraid of & intimidated by the other
- Compromise & negotiation vs. one individual’s terms
  - “My way or the highway”
- How does your partner respond when she or he becomes angry with you?
- How do you and your partner deal with disagreements?
- Do you ever feel afraid of your partner?
Questions to clarify unclear IPV

- Are you afraid of making your partner angry?
- Are you afraid to disagree with your partner?
- Do you need permission to do things or go places without your partner?
- Are you afraid your partner will hurt you?
- Are you afraid to end your relationship with your partner?
Further assessment

- Remember that sexual IPV may be present even if not endorsed, ask again in a future session.
- Assess concerns of lethality of IPV
- Assess risk of suicide and homicide
  - Confidentiality should not be broken if there is no intent or if confident in safety agreement
Ongoing assessment

- “Are there things you would like to do but choose not to in order to avoid potential consequences?”
- “What would happen if you did _____?”
- Does your partner criticize you? In what way, how often? Is it in front of others? Is it humiliating?
- Do you ask permission before you make plans or do things without your partner?
- Is your partner jealous? Is the jealousy rational or irrational?
- Who controls the money? Do you have access to spending money?
FOLLOWING DISCLOSURE OF IPV
Responses to disclosure can counter abuse messages

Abusers tell victims:

- You deserve to be treated like this.
- It’s your own fault for being so (stupid, ugly, fat, useless, lazy).
- Nobody will ever believe you.
- You will be alone forever if you leave me.
- I’m all that you have. There is no hope for you if you leave.

Tell your patients:

- Nobody deserves to be abused.
- It’s not your fault.
- I believe you.
- You are not alone.
- There is help available. You have a number of options.
Following disclosure:

- Frame abusive behavior as concerning, and when relevant as potentially criminal
- Place responsibility for violence unequivocally on abuser
- Document findings carefully and nonjudgmentally in the medical record (*attending to safety issues*)
- Assess for danger
- Initiate safety planning
- Evaluate need for mandated reporting to appropriate agencies for children and elderly or disabled patients
- Refer to or consult with experts as needed
Following disclosure (for MDs):

- When possible, avoid prescribing sedating medications that could impair the victim’s ability to respond appropriately should she or he need to flee
  - If they are being prescribed, discuss these considerations with patient

- Diagnose and refer or treat specific injuries and medical problems related to ongoing or past victimization

- Refer the patient as appropriate to experts
Mandated reporting

- Child abuse, vulnerable adults, SI/HI

HEALTH CARE PROVIDERS:

- It depends on the nature of the victim’s injuries.

- North Carolina does not have a law that requires reports of IPV per se, but some IPV cases result in injuries that fall under reporting requirements.
Health care provider mandatory reporting

- NCGS § 90-21.20(b) requires health care providers to report all firearm injuries, all poisonings, and wounds caused by sharp pointed instrument, and other cases involving grave bodily harm or grave illness if they believe they arose from a criminal act.

- If a patient suffers an injury or illness that requires mandated reporting, the physician or facility administrator must report the injury to law enforcement.

(North Carolina General Statutes)
An IPV screening process that has strong support in health care settings
Documentation of IPV injuries

- Date and time of arrival
- Name, address, and phone number of anyone accompanying the patient
- Primary complaint
- Description of injury-causing event, including patient’s own statements of how injuries occurred (direct quotes)
- Patient’s statements of past abuse incidents (direct quotes)
- A detailed description of injuries, including type, number, and location (record injuries on body charts)
- Name of health care professional who provided treatment
- Documentation that patient was asked about IPV and the patient’s response
- Documentation that injuries were reported to law enforcement if relevant
- Documentation of resource information given for aftercare (e.g., shelters, counseling, victim advocates, etc.)
- Record of non-bodily evidence of abuse (e.g., torn clothing, damaged jewelry)
- Name of translator used, if applicable
Domestic Violence Screening/Documentation Form

Date ______________________ Patient ID# ________________

Patient Name __________________________________________
Provider Name __________________________________________

Patient Pregnant? YES NO

ASSESS PATIENT SAFETY
☐ YES ☐ NO Is abuser here now?
☐ YES ☐ NO Is patient afraid of their partner?
☐ YES ☐ NO Is patient afraid to go home?
☐ YES ☐ NO Has physical violence increased in severity?
☐ YES ☐ NO Has partner physically abused children?
☐ YES ☐ NO Threats of homicide?
  By whom: ____________________________

☐ YES ☐ NO Threats of suicide?
  By whom: ____________________________

☐ YES ☐ NO Is there a gun in the home?
☐ YES ☐ NO Alcohol or substance abuse?
☐ YES ☐ NO Was safety plan discussed?

REFERRALS
☐ Hotline number given
☐ Legal referral made
☐ Shelter number given
☐ In house referral made
  Describe: ____________________________
☐ Other referral made
  Describe: ____________________________

REPORTING
☐ Law enforcement report made
☐ Child Protective Services report made
☐ Adult Protective Services report made

PHOTOGRAPHS
☐ YES ☐ NO Consent to be photographed?
☐ YES ☐ NO Photographs taken?

Attach photographs and consent form
SAFETY PLANNING
Safety Planning

- Discussions **must** consider victim's stay/leave plans
  - Law enforcement
  - Legal options
  - Who they turn to for support
  - Technology – computer, phone histories, tracking systems

- If victim is staying in relationship
  - How victim can be as safe as possible while at home
  - Concerns regarding children are emphasized

- If victim is leaving the relationship
  - Planning a safe exit
  - May be extremely dangerous
Danger Assessment

- Has the physical violence increased in frequency or severity over the past year?
- Has your partner ever used a weapon against you or threatened you with a weapon?
- Do you believe your partner is capable of killing you?
- Does your partner ever try to choke you?
- Is your partner violently and constantly jealous of you?

(Danger Assessment-5; Campbell, 2015)
Safety Planning:
Planning a safe exit

- Victims are often in the greatest danger when they try to leave. Leaving needs to be planned carefully with safety precautions in mind. For help devising a safety plan or for shelter, call the local DV hotline.

- Calling for help
  - The police – 911, friends or family, local DV hotline
  - Keep list of important numbers that are not memorized

- Keep extra set of keys and some money in case of needing to leave home in a hurry
  - Consider making copies of keys and important paperwork and leaving them with a friend, neighbor, work, or place of worship.
Safety Planning:
Preparations for a safe exit

- Keep a bag in trunk of car, in a drawer, or on a particular shelf
- Important documents: birth certificates, passports, social security cards, legal papers (i.e., custody papers, order of protection, marriage certificate)
- Other important documents: car registration and insurance card, deed to house or lease agreement, medical insurance cards or information
- Important information: social security numbers, bank account number, credit card account number and customer service phone number
- Medications
- Money
- Pictures, jewelry, items of sentimental value
- Any relevant evidence (e.g., threatening letters or emails)
Safety Planning:
Planning for danger in the home

- What have you done in the past to protect yourself? What has worked?
- Keep keys in pocket; park with car facing out for a quick exit
- Keep cell phone in pocket or somewhere easy to access
- Safest room in the house? A room with a lock? Ideal are rooms with access to a door or window. Not rooms with weapons (e.g., kitchen). Not rooms one may be trapped in (e.g., closets or bathrooms).
- Where are exits in the home? Plan an exit route from safe room
- Is there a neighbor whose house you can run to?
- How do you feel about calling the police? About an order of protection?
- A code word to use with family or a friend? If you say code word, they will call the police and say you are in danger
911 CALL TRANSCRIPT

• "911, where is your emergency?"
• "123 Main St."
• "Ok, what's going on there?"
• "I'd like to order a pizza for delivery."
• "Ma'am, you've reached 911"
• "Yeah, I know. Can I have a large with half pepperoni, half mushroom and peppers?"
• "Ummm... I'm sorry, you know you've called 911 right?"
• "Yeah, do you know how long it will be?"
• "Ok, Ma'am, is everything okay over there? Do you have an emergency?"
• "Yes, I do."
• "... And you can't talk about it because there's someone in the room with you?"
• "Yes, that's correct. Do you know how long it will be?"
• "I have an officer about a mile from your location. Are there any weapons in your house?"
• "Nope."
• "Can you stay on the phone with me?"
• "Nope. See you soon, thanks."
Alongside planning for a safe exit

- Take time for the victim to articulate why they are leaving. Write things down and keep for future reference.
  - This will be helpful regardless of outcome.
- Identify at least one other treatment goal.
- Problem-solve barriers - practical and emotional.
- Before end of session, confirm next session and specifically voice acceptance of any outcome.
PSYCHOTHERAPY

DEVELOPING TREATMENT GOALS
Developing treatment goals

- Critical to have explicit process of developing goals
  - Will be leveraged in times of ambivalence
- Issue of discrepancy between victim and provider goals
  - Non-collaborative goals should be in therapist’s “background”
  - Often victim hopes to stay in the abusive relationship while improving the relationship or themselves
- Explore the ways that IPV has impacted or impaired the victim’s functioning
  - Health, work, finances, social and spiritual support, parenting
  - Self-esteem, self-confidence, self-worth, self-efficacy
Coexisting Psychological Problems

- Depression
- Anxiety
- PTSD
- Interpersonal problems: isolation, secrecy, assertiveness, problems relating to others, personality disorder traits
- Substance abuse
What about the “blaming the victim” issue?

- The abuse is **NOT** the victim’s fault.
  - Highlight that focus is on victim because for treatment to be productive focus must on presenting person

- Emphasize that goals are focused on:
  - Empowerment – regarding response to abuse & options
  - Helping the victim to understand and cope with how the abuse has affected him or her

- Explore attributions about the abuse
  - Question ways victim takes accountability for abuse
  - Question lack of accountability of the abuser
INTERVENTION: PROVIDING PSYCHOEDUCATION
Adapted from the Domestic Abuse Intervention Project, Duluth, MN
Demystifying the cycle of abuse for the patient

Honeymoon ⇔ building tension ⇔ eruption ⇔ contrition

- Help victim to predict the cycle
- Highlight that intensity of love and attachment is related to the cycle of abuse
- Use behavioral learning principles to explain traumatic bonding
  - Help victim understand how tearing down of self-worth, blaming, shaming, humiliation, self-doubt, and fear relate to relief of making up
Providing Psychoeducation

- Providing information about underlying framework of power and control
- Return to information from assessment highlighting this imbalance
- Abuser is not “out of control” – most abusers do not speak this way or behave this way to others in their lives (e.g., boss, coworkers)
## Common Characteristics of Abusers

- Blames Others for Problems
- Blames Other for Feelings
- Quick Involvement
- Jealousy
- Controlling Behavior
- Isolation
- Hypersensitivity
- Unrealistic Expectations

- Verbal Abuse
- Threats of Violence
- Past Battering
- Breaking or Striking Objects
- Rigid Gender Roles
- Cruelty to Children or Animals
- "Playful" Use of Force in Sex
- Any Force During an Argument
Psychoeducation related to mental health symptoms

- Understanding the function of emotions
  - Anxiety, fear
  - Sadness
  - Anger

- Reality-based understanding of symptoms based on function of emotions
  - Anxiety disorders, Depression, Stress-related disorders
  - Willingness to try standard interventions while acknowledging the unique impact of IPV on disorders such as depression and anxiety

- Personality disorder traits
ONGOING INTERVENTION ELEMENTS
Intervention elements

- Develop discrepancy between ideals and current situation
  - Explore healthy relationship ideals
  - What would you want for your daughter, best friend, etc.
- Is there a “line in the sand”? 
- Use the therapeutic relationship
- Developing alternative paths
- Assessment and development of resources
Strengthening the Therapeutic Relationship

- Highlighting collaborative nature of relationship
  - Contrast to “my way or the highway”
- Demonstrating concern without demands
- Selective reinforcement
- Providing encouragement
- Expressing awareness of patient’s strengths
- Feedback about growth
- Revisiting and revising treatment goals
Developing Alternative Paths

- Generate hope for victim’s personal growth
  - Highlight alternatives whenever possible
  - Improve coping skills
  - Improve parenting skills
- Develop support systems - new resources or “dusty” resources that can be renewed
- End the hour on food for thought
Assessment of Resources

- What would you like to see happen? What would you like to do? Have you ever tried to do that?
- What options might you have?
- Can you remember a time when you felt like this before; what has helped you in the past?
- Are there things you are afraid to do that I can help you with?
- Who have you talked to? Who would you like to talk to if you could?
- Provide information about relevant resources including agencies, shelters, law enforcement, legal options
Provide resources

- National resources
- Local resources

Please contact me for resources!

noga.zerubavel@duke.edu
Remember: Success is…

- Empowerment.
- Knowledge.
- Success is not measured by whether the victim leaves the abusive relationship, but rather by whether the victim knows help is available.
Thank you.

You are welcome to contact me with questions or feedback, and requests for resources or consultation.

Noga Zerubavel, PhD
noga.zerubavel@duke.edu
Director, Stress Trauma and Recovery Treatment Clinic