The Effects of Trauma on Women of Reproductive Age

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National Health Resource Center on Domestic Violence

Provides free technical assistance and tools including:

- Clinical guidelines
- Documentation tools
- Posters
- Pregnancy wheels
- Safety cards
- State reporting laws
- Training curricula

Learning Objectives

As a result of today’s training, you will be able to:

1. Apply three strategies to address vicarious and other forms of trauma among staff to support effective responses to violence and abuse

2. Understand the importance of moving beyond screening for domestic violence and reproductive coercion to doing universal education with every patient/client as a part of a trauma informed and culturally aware practice
Definition of Cultural Humility

“...not a discreet endpoint, but a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with clients, communities, colleagues, and with themselves.”

- Leland Brown, 1994

• How do we connect with systems, staff and clients experiencing trauma?

According to a 2013 report by Gallup

Employees are vastly more satisfied and productive, it turns out, when four of their core needs are met:

1. **Physical**, renew and recharge at work;
2. **Emotional**, by feeling valued and appreciated
3. **Mental**, when they have the opportunity to really focus and define when and where they get their work done; and
4. **Spiritual**, by doing more of what they do best and enjoy most, and by feeling connected to a higher purpose at work.

Name one simple way we achieve greater good in workplace for both ourselves and our work?
Change the way we measure success?

• Employees who take a break every 90 minutes report a 30 percent higher level of focus than those who take one or no breaks.

• Those that took breaks had 50 percent greater capacity to think creatively and a 46 percent higher level of health and well-being.

• Beyond 40 hrs — and the more continuously they work — the worse they feel, and the less engaged they become. (Maunori, et al, 2016)

“If we are to do our work with suffering people and environments in a sustainable way, we must understand how our work affects us.”

-Laura Van Dernoot Lipsky, 2008
(quote from Trauma Stewardship)

What is Vicarious Trauma?

Vicarious trauma is a change in one’s thinking [world view] due to exposure to other people’s traumatic stories.

(Dr. David Berceli, 2005)
What are Common Reactions to Caring for Survivors of Trauma?

• Fear
• Helplessness
• Sleep disruptions
• Depressive symptoms
• Feeling ineffective with clients
• Recurrent thoughts of threatening situations

Common Reactions to Caring for Survivors of Trauma

• Reacting negatively to clients
• Thinking of quitting clinical [contact with clients] work
• Chronic suspicion of others

Pair and Share Exercise (2 min)

• What helps me sustain my work?
• What gets in the way of sustaining my work?
A Tandem Exercise

• Self-care does not replace the need for organizational changes that better support our workforce, nor does organizational change take away the need for us to have our own personal self-care practices. Self-care and organizational support need to both exist for a more balanced work environment.

…http://traumainformedoregon.org/mobile-apps-for-self-care/

Changing the landscape of trauma begins with us.

Mindfulness based stress reduction for health care providers and patients has been studied for 35 years

Nursing Workplace Examples:

• Poorer health due to stress reactivity (immune, autonomic, nervous system, and endocrine system)
• High blood pressure
• Lack of work satisfaction
• Impacts staff retention/costs to health system
• Absenteeism
• Inability to concentrate
Mindfulness Based Intervention (MBI): To Increase Resiliency and Work Engagement

• Intervention Arm
• 40% reduction in stress hormones
• Significant difference in Breaths/30sec
• Significant increase in work engagement, vigor, and dedication (Utrecht scale)
• Increase in resiliency scores (Connor-Davidson Resiliency Scale)
• Improved job satisfaction scores (Klatt et al., 2015)

MSR Strategies

• Breathing
• Grounding

• Self-Talk
• Imagery
Rainstorm Exercise

Perinatal and Interconception Health

Large Group Discussion

How does domestic violence impact women's perinatal health and their birth outcomes?
Show of Hands

What percentage of your clients’ pregnancies have been unplanned?

(Sarkar, 2008; Goodwin et al., 2000; Hathaway et al., 2000)

DV increases women’s risk for UNINTENDED PREGNANCIES

Reproductive Coercion (RC) involves behaviors aimed 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. More specifically, RC is related to behaviors that interfere with contraception use and/or pregnancy. These behaviors may include:

• Explicit attempts to impregnate a partner against her wishes
• Controlling outcomes of a pregnancy
• Coercing a partner to have unprotected sex
• Interfering with birth control methods
Moving Beyond Screening: Universal Education

Breaking Bad

What happens when screening allows staff to miss the point?

- How many of you have ever been screened for domestic violence?

Think about EXACTLY what happened.

- Was it a good experience?
- Was it a bad one?

DO NO HARM

- What is your goal for DV screening?
  - Data collection?
  - Education?
  - Support?
- How do you define success?
- How does your program define success?
Breaking Down Institutional Barriers

What is getting in the way?

• Persistent systematic and personal barriers to screening
• Child protection services (CPS) reporting fears
• Staff’s own personal and/or vicarious trauma
• Limitations of screening tools in this context

Barriers to Identifying and Addressing DV

Providers identified the following barriers during the implementation phase of a perinatal home visitation program to reduce domestic violence (DV):

• Comfort levels with initiating conversations with clients about DV

Group Discussion

• We take care of ourselves by presenting questions and educational messages in a way that feels most comfortable to us.
True Domestic Violence Screening Stories

• “No one is hurting you at home, right?” (Partner seated next to client as this is asked)—How do you think that felt to the client?

• “Within the last year has he ever hurt you or hit you?” (Nurse with back to you at her computer screen)—Tell me about that interaction...

• “I’m really sorry I have to ask you these questions, it’s a requirement of the program.” (Screening tool in hand)—What was the staff communicating to the client?

Show of Hands

• How many of you have or know someone who has ever left something out of a medical history or intentionally misreported information to their health care provider?

• Why? What were they worried about?

What if we challenge the limits of disclosure driven practice?
MIECHV Story

• All home visited moms screened routinely for domestic violence
• Prevalence of DV 14-52% among HV moms
• State average positive disclosure rate? 4-5%  
  (Sharps et al., 2008)

• Why weren’t Mom’s telling us what was happening to them?

What Is a Mother’s Greatest Fear?

“If mandatory reporting was not an issue, she would tell the nurse everything about the abuse...”

• “I say no [when my home visitor asks about abuse] because that’s how you play the game...People are afraid of social services. That’s my biggest fear....”

• “Like I was saying about my friend, the reason she don’t [disclose] is because she thinks the nurse is going to call children’s services...she avoids the nurse a lot”  
  (Davids & et al., 2012)
Identification and Assessment of Intimate Partner Violence in Nurse Home Visitation

• Results: The use of structured screening tools at enrolment does not promote disclosure or in-depth exploration of women’s experiences of abuse. Women are more likely to discuss experiences of violence when nurses initiate non-structured discussions focused on parenting, safety or healthy relationships.

(Jack et al, 2016)

Brave Space

• We are asking the field to move into what is called a ‘Brave Space’—what comes to your mind as you think about this?

• Often ‘Brave Spaces’ are spoken of in relation to ‘Safe Spaces’ (Arno, 2013; Boonstrom, et al 1998)

• We are asking the field to consider their power dynamics relative to racism, disparities, poverty, over involvement in the system and how this fits in for screening for trauma

Universal Education with Parents about Trauma: Doesn’t Exclude Those Who Can’t Share Their Story

• Assumes everyone may have a history of abuse and will benefit from knowledge, tools, and support

• Normalizes the prevalence of reproductive coercion/domestic violence and assures that the conversation doesn’t feel judgmental

• Empowers staff and clients to understand the connections to reproductive health self, health, and gives them access
**CUES Universal Education approach**

**C: Confidentiality:** Disclose limits of confidentiality & see patient alone

**UE: Universal Education + Empowerment:**

*Normalize activity:*

“We’ve started giving two of these cards to all of my clients—so you have the info for you and so you can help a friend or family member if it’s an issue for them.”

*Make the connection: Open the card and do a quick review:*

“It talks about healthy and respectful relationships, ones that aren’t and how they can affect your health. It also talks about what to do if your partner is trying to get you pregnant when you don’t want to be.”

**S: Support:** “The card talks about everyone deserving support and has a safety plan on there and the back there are 24/7 confidential hotlines to support you or anyone you know might need help.”

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**Group Activity**

*Take a couple of minutes and read the card carefully.*

- How does using the safety card support both staff and clients?
- Pay attention to what stands out for you

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**Quick Activity**

- Turn to the person next to you or behind you and give them your card and, in turn, they should give you theirs.
- What happens when you give the card to someone?
1. Universal Education
You might be the first person who ever talked with her about what she deserves in a relationship.

2. Have a Conversation about DV
You might be the first one to talk with her about what she doesn’t deserve in her relationship.

How might this safety card enhance client care?

Did You Know Your Relationship Affects Your Health?
Develop partnerships with local family planning organizations

Among women who received the safety card intervention and experienced recent partner violence:

- 71% reduction in the odds of pregnancy pressure and coercion compared to control group
- 60% more likely to end an unhealthy abusive relationship compared to control

(Miller et al, 2011)
Training Recap

• Self care, mindful movement, trauma informed programming,

• Domestic violence its impact on perinatal health and repro coercion

  • Universal education using safety card recognizing that screening alone misses folks that are too afraid or not ready to talk about it

Mindful Movement

• Wrap your arms around yourself—left hand over right arm and rub your arm

• Switch arms

• Stretch arms in the air, wiggle fingers, shake hands

• Come back to center

It’s About All of Us

• “Compassion is not a relationship between the healer and the wounded. It’s a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our shared humanity.” - Pema Chödrön