The Impact of Physical Abuse & Sexual Assault on a Woman’s GYN & Reproductive Health Outcomes

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Key Objectives

- Demonstrate the connection between violence and reproductive health issues (data)
- Discuss focused assessment strategies ("how to’s")
- Identify opportunities for intervention and preventing long-term reproductive health consequences (what & when)
Childhood Sexual Assault Increases Risk of Rape

Young women who were sexually abused or witnessed domestic violence as children are 4 times more likely to experience rape or attempted rape between ages 16-18 years.

Fergusson DM, Horwood LJ, Lynskey MT, 1997
Dating Violence

- 1 in 5 female high school students disclosed physical and/or sexual violence from dating partners (Silverman et al, 2001)

- 17.8% of high school girls were forced to engage in sexual activity by a dating partner (US DOJ, 1997)
Sexual Risk Behaviors: Dating Violence

For women, a history of dating violence is associated with an increased risk of:

- Substance abuse before intercourse (Silverman et al, 2001)
- Less perceived control over their sexuality (Wingood et al, 2001)
More than one-third (38.8%) of adolescent girls tested for STI/HIV have experienced dating violence.

Decker et al, 2005
STIs and IPV

- Women disclosing physical abuse were three times more likely to experience a Sexually Transmitted Infection (STI) (Relative Risk, or RR = 3.13).

- Women disclosing psychological abuse were nearly twice as likely (RR=1.82) to experience an STI.

Coker et al, 2000
Sexually Transmitted Infections and Intimate Partner Violence (IPV)

40% of women with a history of physical, emotional, and/or sexual abuse had been diagnosed with one or more sexually transmitted infections (STIs) compared with 18% of women with no history of abuse.

Letourneau et al, 1999
Overlapping Epidemics: HIV and IPV

Based on a study of 310 HIV-positive women:

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

Gielen et al, 2000
Women with a history of DV are more likely to experience:

- **Dysparunia, dysmenorrhea, vaginitis & other GYN dx** (Letourneau et al, 1999)

- **Pelvic inflammatory disease** (Schei, 1991)

- **Chronic pelvic pain syndrome** (Coker, 2000)

- **Invasive cervical cancer and invasive cervical neoplasia** (coker, 2000)
Birth Control (BC) Sabotage: Domestic Violence

Strategies include:

- destroying diaphragms
- flushing BC pills down the toilet
- saying that sex doesn’t feel right with condoms

Campbell et al, 1995
In their own words.....

- “My husband would get mad and throw the pills in the trash or take them to work with him”
- “At one time I had three diaphragms. If he found one and threw it away, that was fine, I would get my backup I had hidden in the house.”

Campbell et al, 1995
Birth Control Sabotage

- Girls who experienced physical dating violence were 2.8 times more likely to fear the perceived consequences of negotiating condom use than nonabused girls (Wingood et al, 2001)

- Women experiencing DV were threatened with abandonment when they asked their partners to use condoms (Wingood et al, 1997)
Pregnancy, Sexual Violence, & Early Sexual Debut

* Nearly two-thirds of pregnant adolescents disclosed childhood sexual abuse and/or rape prior to their first pregnancy

and

* Abused pregnant teens initiated sex two years earlier than nonabused pregnant teens

(Boyer et al, 1992)
Dating Violence & Teen Pregnancy

Adolescent girls who experienced physical or sexual dating violence were 6 times more likely to become pregnant than their non-abused peers.

(Silverman et al, 2001)
Adolescent Pregnancy

- Boyhood exposure to DV is associated with an increased risk of male involvement in a teen pregnancy

(Anda et al, 2001)
Unintended Pregnancy

40% of pregnant women experiencing abuse reported that the pregnancy was unwanted compared to 8% of nonabused pregnant women

(Hathaway et al, 2000)
Unintended Pregnancy

Domestic Violence is associated with unwanted or mistimed pregnancies:

Women living with DV were 4 times more likely to have an unwanted or ill timed pregnancy compared to women not exposed to DV.

(Gazmararian et al, 1995)
Rapid Repeat Pregnancies

- Low income adolescents who experienced physical or sexual abuse were:

  * 3 times (OR=3.46) more likely to have a rapid repeat pregnancy within 12 months.

  * 4 times (OR=4.29) more likely to have a rapid repeat pregnancy within 18 months

(Jacoby et al, 1999)
Clinical Implications:

‘Noncompliant’ patients who don’t routinely use contraception, have unintended pregnancies, multiple pregnancy tests, and STIs should be considered at risk for trauma & Domestic Violence /Sexual Assault.
Clinical Implications

‘Noncompliant’ / ‘frequent flyer’ patients should trigger a clinical assessment for DV/SA. We should be asking:

“Can you talk to your partner about birth control? Is he supportive of your choices? Do you feel like you can say no to sex without feeling frightened?”
Prevention Opportunity: Revictimization

Female survivors of childhood sexual abuse are at significantly higher risk of sexual and physical revictimization as adults.

(Boyer et al, 1992; Muehlenhard et al, 1998; Nagy et al, 1995)
Prevention Opportunity: Revictimization

College women who experienced physical dating violence as adolescents were 3 times more likely to be revictimized during their freshman year than nonabused females and the elevated risk continued for each subsequent year of college.

(Smith et al, 2003)
Screening & Assessment Reduces Violence

Women screened for abuse were randomized into two intervention groups:

- One group received a wallet-sized referral card
- Once group received a 20-minute nurse case-management intervention

(McFarlane et al, Nursing Research, V. 55, No. 1, 2006)
Screening & Assessment Reduces Violence

At 2 year follow-up, both treatment groups reported fewer:

- Threats of violence
- Assaults
- Danger risks for homicide
- Events of work harassment
*Screening & Assessment is Intervention*

- Listening and affirmation are invaluable to survivors (Whiteman, Chamberlain & Greenwood, 2005)

- Women who talked to their nurse or provider were nearly 4 times more likely to use an intervention (McCloskey et al, 2006)

- At 2-year follow-up, women who were screened for abuse and given a wallet-size referral reported fewer threats of violence, assaults and harassment at work (McFarlane, 2006)
Elements of a Clinical Response

- Screen using culturally appropriate language about BOTH past and current victimization

- Assess for safety; provide safety education and supportive messages

- If Behavioral Health (BH) screening is positive, provide referrals or offer direct access to BH

- Provide referrals to Tribal Victim Assistance Programs, shelter services, other care/services

- Document findings
Strategies for DV/SA Assessment: Women’s Health & Reproductive Health

- Screening and Safety Planning at
  - Initial & annual GYN visits
  - Birth Control Options Counseling
  - Emergency contraception (EC)
  - Pregnancy tests
  - STI/HIV visits
Strategies for Perinatal & Newborn / Pediatric Care

- Screening and Safety Planning at
  - Initial and f/u prenatal visits
  - As part of postpartum discharge counseling
  - At 6 week post partum visit
  - At newborn visits
Facility Strategies for all Primary Care / Chronic Disease (Planned Care) Visits

- Screen all adolescent and adult females coming in for care regardless of reason for care
- Bundle BH, DV and other primary care screens together
- Improve access to BH services with immediate access to a credentialed provider
Strategies for Reproductive Health

Incorporate screening questions for lifetime exposure to violence during:

- Initial & annual visits
- Birth Control Options Counseling
- Emergency contraception (EC)
- Pregnancy tests
- STI/HIV visits
Strategies for Reproductive Health

Use screening questions for lifetime exposure to violence to assess for risk behaviors correlated with victimization including:

- Substance abuse
- Depression
- Sexual risk behaviors
Elements of a Good Assessment

- Culturally informed assessment questions
  - It is PRIVATE (no children)
  - Language: Partner vs. boyfriend vs. friend
  - Normalizing (Use prevalence statistics)
  - Programmatically relevant (different questions for WIC setting vs. clinical setting vs home setting)
  - Culturally sensitive and appropriate
Elements of a Good Screening / Assessment

- Confidentiality
  - Mandatory Reporting
  - CPS
  - Charting, Staff, and HIPPA

- Bilingual staff (culturally appropriate language)

- Translation (Staff only)
Clinic Environment

- Form an Interdisciplinary Team to lead your DV / SA response efforts
- Include your security, receptionist and admin staff on your team
- Change your clinical environment
  - Posters
  - Safety cards (exam rooms/bathrooms)
  - Protocols
- Provide private space for screening where patients feel safe
- Make meaningful connections with other culturally relevant community programs
Potential Screening Tools

- Self administered questionnaires
- Sensitive DV/SA assessment
- Clinical assessment based on history, physical examination, sensitive probing
- Scripted tools
Scripted Assessment: Dating Violence

“Do you ever feel afraid or controlled by someone you’re dating or by a friend?”

“Has anyone forced you to have sex or do things that you did not want to?

FVPF Consensus Recommendations, 2002 [endabuse.org]
Assessment: Childhood Sexual Abuse

- When you were a child or teenager, did you ever have any unwanted sexual experiences?

- Did anyone force or persuade you to have sexual intercourse against your wishes before age 17?

(Bifulco et al, 1994)
Assessment: Unwanted Sex

- Would your partner break up with you unless you would have sex?
- Does your partner ever make you have any kind of sex when you don’t want to?
- Would your partner get mad at you if you didn’t want to have sex?

Blythe et al, 2006
Assessment: Lifetime Sexual Aggression/Assault

- Has a partner ever had sex with you when you didn’t want to because you felt pressured by the reasons he/she gave you?

- Has a partner ever had sex with you when you didn’t want to because he/she used force?

(Kenney et al, 1997)
Assessment: Abortion services

- Was your decision to have this abortion made because of physical or sexual abuse? (Wiebe & Janssen, 2001)

- Was your decision to have this abortion because of a partner’s abusive behaviors or threats of harm?
Assessment: Verbal BC Sabotage

Study participants were asked if their partner had said any of the following things in the past 12 months:

- “You want to use family planning so you can sleep with other men”
- “You would have my baby if you really loved me”

(Center for Impact Research, 2000)
Birth Control Sabotage

Study participants were asked these yes/no items:

- “My boyfriend won’t let me use family planning”
- “My boyfriend forces me to have sex when I am not protected”

(Center for Impact Research, 2000)
Screening / Assessment Tip: Use A Script

– “Violence is common in women’s lives and often effects women’s health, so I ask all my clients if they were ever forced to do something sexual they did not want to do..”

– “...or if any partner ever hurt you or made to feel afraid.”

– Other tools: National Consensus Guidelines
Annual Exam Assessment: Use a Script

- “Has there been a change in your sexual partner or have there been any additional partners since the last time you came in?”

- “Can you talk to your partner about birth control? Is he supportive of your decisions?”

- “Do you ever feel like he wants you to be pregnant when you don’t want to be?”

- “Are you ever hurt or threatened by him?”
Birth Control Counseling: Use a script

“I want to talk with you about your birth control method and what best fits into your life. Some women have to worry about their partner not using condoms or interfering with their birth control which can make them nervous they will get pregnant.

Has this ever happened to you?”
Emergency Contraception: Scripted IPV Screening

“So you’re in for the morning after pill. I’m glad you knew about it… Can you tell me about the first day of your last period and any unprotected sex you’ve had after that including the most recent time. I always ask all of my patients whether or not the sex you had was coerced or something you didn’t want to happen?”
Screening for Coercion: Use a Script

“While we wait for your pregnancy test results, I wanted to talk with you about your sexual partners. Sometimes a partner may try to get you pregnant when you don’t want to be or make you have sex when you don’t want to. Or they may hurt you or makes you afraid. This happens to many women...is this something that has happened to you?”
Forced Sex: Scripted Response

- I am sorry that happened to you. I know that it can be confusing to sometimes have sex with someone when you want to, but then have that partner force you to have sex against your will at other times.

- Nobody, including your partner, has the right to touch you or force you to do anything sexually that you don’t want to do no matter what. Have you been able to talk to anyone about what happened?
DV or Forced Sex: Scripted Response

“I’m sorry that happened to you. It happens much too often to too many women. There are some resources for you, and people you can talk to who really understand what you have gone through. They have worked with many other women who have had the same thing. I am going to give you a name and the phone number to our community advocate.”
Stats from a Healthy Start Site: Things to Consider in Program Assessment

- 213 female clients were screened for DV
- 36% screened positive for DV
- Screening rates varied by site
- Positive disclosure rates also varied
  - One site had zero disclosures
  - Another site 6 miles away had a positive disclosure rate of 46%
“I’m sorry that you have been hurt. It is not your fault and you don’t deserve to be treated like that. Have you been able to talk to anyone about this?”
Scripted Response: IPV Disclosure

“I am worried about your safety since you told me about your partner hurting you. Is the person you told me about in the clinic today? Are you in immediate danger? Are there weapons in the house? Has he ever tried to strangle you? Have you ever been afraid for your life?”
“Is there anyone you would consider talking to about this or who would help you if you were hurt? We know that connecting with supportive people that are safe really helps women emotionally and physically too. Sometimes even calling a hotline number can help so you always have a place to turn...”

Provide safety planning counseling and community resource information
Institutional Response: Policies and Guidelines

- DV Workplace programs
- Staff diversity/Staff readiness/Confidentiality
- Managing vicarious trauma
- At least annual staff training on screening & safety counseling for all adolescents and women
- Required CEUs for providers on DV and sexual assault
- Quality assurance/Quality Improvement focused on DV / SA
- Culturally appropriate materials
Defining Success

- Create a safe environment for women/teens to disclose and share their experiences
- Help women/teens to understand how violence impacts health and behavior
- Validate women/teens experiences and provide supportive messages
- Increase women/teens awareness about options, safety behaviors / planning, and linkage to services
Defining Success

- One measure of success is to make relevant services accessible, for example, finding out if your community has a DV or SA victim’s advocate and providing transportation for the victim who may not otherwise be able to access services;

- Our job is not to get women/teens to disclose or to “fix” intimate partner violence or tell victims what to do;

- We can help victims by understanding their situation, recognizing how abuse can impact reproductive health and risk behaviors, and offering them assistance like a ride to the clinic;

- Another measure of success is reducing isolation and improving options for safety.
Thank You

- Remember to enjoy your work.

- You are providing life saving information and support.

- Remind yourself that screening, education and safety planning are interventions and they are enough.