Coping with Hope 2014
The HIV Care Continuum

The Dangerous Intersection of
INTIMATE PARTNER VIOLENCE (IPV) & HIV
Presented by

Susan Holt, PsyD, LMFT, CCDVC,
Manager, STOP Partner Abuse/Domestic Violence Program
L.A. Gay & Lesbian Center

323.993.7645
sholt@lagaycenter.org
STOP Partner Abuse/Domestic Violence Program

Support
Treatment/Intervention
Outreach/Education
Prevention

323.860.5806
domesticviolence@lagaycenter.org

Survivors’ services
Court-approved Batterers’ Intervention Program
Prevention services
• Founder & Director of STOP Partner Abuse/Domestic Violence Program.
• Conducted first LGBT domestic violence services in Southern California in 1987.
• Co-Founder & Former Chair, LGBT Issues Committee, L.A. County Domestic Violence Council
• Former Representative, 4th Council District, City of L.A. Domestic Violence Task Force
• Former Co-Chair, Multicultural & Underserved Communities Committee, City of L.A. Domestic Violence Task Force.
• Advisory Board, Westside Domestic Violence Network.
• Former Board President, Statewide California Coalition for Battered Women.
• Adjunct Faculty, Antioch University; Pacific Oaks College.
• Author, Disparities Report/LGBT Domestic Violence, California Department of Mental Health Services (First, Do No Harm).
• Consultant, First White House Roundtable on LGBT DV.
• Community Author, CA Senate Bill 564 (Speier); Assembly Bill 2051 (Cohn); Assembly Bill 1003 (Perez). (Equality in Prevention & Services for Domestic Abuse).
What will be covered?

• Basic – intermediate level information about heterosexual and LGBT domestic violence. The focus will be on intimate partner violence – primarily in the gay and MSM populations - and its intersection with HIV.
• Types of Intimate Partner Violence
• Dynamics of Abusive Relationships
• Internalized Homo/Bi/Transphobia & Intimate Partner Violence
• Unique Aspects of Intimate Partner Violence When HIV is Present
• Substance Abuse & Intimate Partner Violence
• Screening & Detection Strategies
• Assessment of Intimate Partner Violence
• Standards of Care
• The Basics of Intervention & Treatment
• Community-based Resources
• Reporting Requirements
Goals for Training

• Provide you with a basic - intermediate understanding of intimate partner violence & its intersection with HIV.
• Give you a solid understanding of the unique aspects of intimate partner violence when HIV is present.
• Increase your ability to accurately detect and assess for intimate partner violence and differentiate between abuser and victim.
• Help you identify and utilize community-based resources.
• Provide you with an understanding of basic – intermediate interventions.
Terminology

• Survivor / Victim

• Abuser / Batterer / Aggressor or Primary Aggressor/Perpetrator

• Client/Patient

• Intimate Partner Abuse & Violence (IPV) / Domestic Violence / Family Violence
Family Violence includes violence in relationships between adult partners, parent/child, siblings, extended family members, & caregivers. Includes child, elder, & dependent adult abuse.

Domestic Violence includes violence in intimate partnerships and can include child abuse & pet abuse within the family setting.

Intimate Partner Violence specifically differentiates between intimate partners and other family members and is inclusive of all intimate partnerships, regardless of legal marital status or sexual orientation/identity.
Intimate Partner Violence is a systemic pattern of abusive and violent behavior used by one person in an intimate relationship to gain and maintain power and control over the other (NCAVD, 2010, NRCDV, 2007).
Intimate partners include current and past spouses and non-marital domestic and dating partners. It is not necessary for partners to be cohabitants or for the relationship to involve sexual activities (Saltzman, Fanslow, McMahon, Shelley, 1999).
What Intimate Partner Violence Is Not

• A communication issue or style.

• A relationship problem.

• The result of stress.

• The result of anger management difficulties.

• An impulse control problem.

• Codependence.

• The result of substance abuse.
Why is an understanding of intimate partner violence important?
- High prevalence
- High risk factor for HIV

If un-assessed or incorrectly assessed, intimate partner violence can...

- Increase your client’s risk for co-morbidity & additional health & mental health problems;
- Jeopardize the client’s safety and the safety of his/her children, family members, friends, & community-at-large;
- Undermine any intervention or treatment you conduct;
- Increase your liability as a service provider as well as the liability of the organization where you work.
Myths & Misconceptions

- Domestic violence usually affects people in lower socioeconomic classes.
- Domestic violence is more pervasive in certain cultures.
- Domestic violence is caused by the use of drugs or alcohol.
- Domestic violence is a private matter between the people involved in it.
- Domestic violence seems to be more common than it used to be.
LGBT IPV Myths & Misconceptions

- Women are generally not violent.
- When women are violent, the violence they perpetrate is not as severe as the violence perpetrated by men.
- Men are not commonly victims of intimate partner violence.
- Physical size and strength determine which partner is most apt to be violent.
- Gender or gender roles determine which partner is most apt to be violent.
- It is easier for LGBT victims to leave abusive relationships than it is for heterosexual victims to do so.
- LGBT intimate partner violence is mutual.
- LGBT intimate partner violence usually manifests as common couple violence.
- Discussion of LGBT intimate partner violence tends to increase societal prejudice & discrimination against LGBT people.
- Male victims can generally access battered women’s resources & services.
- Transgender domestic violence is more similar to heterosexual domestic violence than to same-gender domestic violence.
The Realities:

Intimate partner violence affects individuals and families in every community & population regardless of race, nationality, ethnicity, sexual orientation, age, socioeconomic status, educational background, political affiliation, religion, gender, ability, etc. (NCADV, 2010; OVW, 2007)

and

has significant health, mental health, criminal justice, and public safety ramifications (FVPF, 2009).
• IPV is the major cause of death and injury to women in the U.S. and exceeds rapes, muggings, and automobile accidents combined (Clark County Prosecuting Attorney, 2010; College of Family Physicians, 1999).

• IPV is the third leading cause of homelessness in the U.S. (U.S. Department of Housing & Urban Development, 2011; CA DPH, 2007).

• Of those murdered by their partners, 74% are women and 26% are men (Rennison, 2001).

• On average, more than 3 women a day in the U.S. are murdered by their husbands or boyfriends (Catalano, 2007).

• IPV calls constitute half of all violent crime calls to the police (Cassidy et al, 2001).

• The majority of IPV incidents are never reported to police (NCADV, 2014).

• IPV is the most dangerous situation for police (Piazza, 2010).
• At least one-in-three women globally will be beaten, raped, or otherwise abused during their lifetimes by a family member (UN Development Fund, 2003).

• Nearly one-in-four women in the U.S. report experiencing violence by a current or former spouse or boyfriend at some point in their lives (CDC, 2008).

• One-in-three adolescent girls in the U.S. is a victim of physical, emotional, or verbal abuse from a dating partner (Davis, 2008).

• Those with disabilities are more likely to suffer IPV than those without disabilities. And those with disabilities report abuse that lasts longer and is more intense than those without disabilities. (Office of Women’s Health - U.S. Dept. of Health and Human Services, 2014).

• Teen victims of physical dating violence are more likely than their non-abused peers to smoke, use drugs, engage in unhealthy behaviors such as taking diet pills or laxatives or inducing vomiting to lose weight, engage in risky sexual behaviors, and attempt or consider suicide (Silverman & Raj, 2001).
• Women experience 2 million injuries from intimate partner violence each year (CDC, 2008).

• Only 1 in 5 intimate partner violence victims with physical injuries seek professional medical treatment (Greenfield, 1998).

• Women who experience domestic violence are 80% more likely to have a stroke, 70% more likely to have heart disease, 60% more likely to have asthma, and 70% more likely to drink heavily than women who have not experienced it (CDC, 2008).

• Domestic violence can increase the risk of HIV infection and re-infection, other STD’s, and eating disorders, internal bleeding, broken bones, head trauma, severe lasting disabilities, chronic gynecological and central nervous system problems and death (Williams, 2008).
• Gay and bisexual men who are victims of IPV are more likely to report suffering from serious health problems including heart disease, hypertension, depression, anxiety, and are more likely to engage in unhealthy behaviors such as substance abuse and unprotected sex (Journal of Urban Health, 2007).

• Men infected with HIV are at higher risk for psychological and physical abuse from male partners than their HIV negative peers (Greenwood et al, 2002).
• Despite sample sizes and methodologies used, an approximate average IPV rate of 25% - 33% of lesbian and gay individuals is consistent over time (Fountain, Mitchell-Brody, Jones & Nicols, 2009).

• 32% of gay and bisexual men are victims of intimate partner violence (Journal of Urban Health, 2007).

• LAGLC STOP DV meta study (2008): Highest DV case count (1483) with statistically independent data ever conducted (NCAVP, 2009). Intimate partner violence frequency = 56%. If verbal assaults had been considered to meet the standard for violence, the frequency would have been 71%. 
• California Health Interview Survey (UCLA, 2010): 28% of lesbian or gay adults and 40.6% of bisexuals residing in California compared to 16.7% of heterosexual adults reported having experienced intimate partner violence in adulthood.

• Centers for Disease Control (2013): Lifetime levels of sexual and physical violence among lesbians and gay men are equal to or higher than those of heterosexuals. 61% of bisexual women & 47.4% of bisexual men reported rape, physical violence and/or stalking by a partner. 43% of lesbians and 40.2% of gay men reported these behaviors compared to 35% of heterosexual women and 20.8% of heterosexual men.
Outcomes

- Physical injury or death
- HIV infection & re-infection
- Sexually transmitted diseases
- Exacerbation of acute and chronic medical conditions
- Non-adherence with medical / mental health treatment
- Suicide / Suicide Attempts
- Homicide
- Substance abuse
- Eating disorders
- Gynecologic problems
- Complications of pregnancy & childbirth
- Internal bleeding
- Broken bones
- Head trauma
- Lasting disabilities
- Central Nervous System problems
- Mood disorders
- Anxiety disorders
- Dissociative disorders
- Social isolation; Loss of support from family and friends
- Significant psychological distress
- Compromised health and well-being of children and others close to victim
IPV is recognized as a violation of human rights, a public health problem, a criminal justice problem, a civil rights issue for the LGBT community, and an epidemic that overlaps with the HIV/AIDS epidemic.

Where & How do HIV & IPV intersect?

• Direct transmission through sexual violence.
• Indirect transmission through sexual risk taking.
• Indirect transmission through inability to negotiate safer sex practices / condom use.
• Violence as a consequence of being HIV +.
• IPV increases the risk of acquiring and transmitting HIV (U.S. Dept. Health & Human Services, 2011; Women’s Interagency HIV Study).
• Victims of IPV are 1.5 times more likely to contract HIV than those who have not experienced IPV (World Health Organization, 2013).
• Abuse is high among women with or at risk of HIV and between 24 – 78% report a history of violence (Women’s Interagency HIV Study).
• Episodes of IPV dramatically increase the short-term risk of death for women living with or at risk of contracting HIV (International AIDS Conference, Washington D.C., 2012).
• IPV among women with HIV, or those at risk for HIV, may be as high as 67%, a rate that is 3 to 4 times greater than among HIV negative women (Cobb, 2008; Brief et al, 2006).
• 1 in 5 men are physically battered and 1 in 20 are sexually assaulted by a partner (Relf et al, 2004).
• 41% of LGBT individuals have been forced by their partners to have sex (Heintz & Melendez, 2006).
• 28% felt unsafe to ask their abusive partners to use safer sex protection or feared their partners’ response to safer sex and 19% experienced sexual abuse, 21% experienced physical abuse, and 32% experienced verbal abuse as a direct consequence of asking their partner to use safer sex protection (Heintz & Melendez, 2006).
• Discussing safer sex within a violent relationship often escalates abuse (Pajouhi, 2000; Cobb, 2008; Gore-Felton et al, 2007).

• HIV status may impact the decision to stay or leave an abusive partner (Letellier, 1996).

• 69% of battered gay and bisexual men who were HIV + indicated that the fear of becoming sick and dying alone played a major part in the decision to remain in an abusive relationship (Merrill & Wolfe, 2000).
Intimate Partner Violence is a systemic pattern of abusive and violent behavior used by one person in an intimate relationship to gain and maintain power and control over the other (NCAVD, 2010, NRCDV, 2007).
When one form of abuse exists, it is generally coupled currently or in the future with other forms of abuse.

Intimate partner violence generally begins with emotional/psychological abuse and, in many cases, will escalate to physical and/or sexual violence.
Types of Behaviors Associated with Abuse

• Psychologically / Emotionally Abusive Behaviors

• Physically Abusive Behaviors

• Sexually Abusive Behaviors

• Environmentally Abusive Behaviors (those involving status)
Examples of Psychological/Emotional Abuse:

• Humiliating the other
• Undermining self-esteem of the other
• Name calling
• Lying
• Intimidating the other
• Verbal degradation
• Using profanity
• Forcing isolation
• Shouting
• Yelling
• Threatening
Examples of Physical Abuse:

- Hitting
- Slapping
- Punching
- Choking
- Shoving
- Biting
- Burning
- Stabbing
- Restraining
- Kicking
- Scratching
- Pulling hair

Note: These behaviors may not result in physical injury. The degree of injury is not what defines whether an action is abusive. It is the behavior itself and the atmosphere of intimidation that is created that defines abuse.
Examples of Sexual Abuse:

- Shaming, demeaning and / or humiliating the partner’s sexuality or sexual behaviors.
- Raping
- Refusing to practice safer sex
- Failure to be honest with partners about one’s sexual activities/related illnesses, etc.
- Deliberate infection of HIV / STD’s
- Forcing prostitution
- Forcing sexual activities unwanted by the other.
- Sexual exploitation through photography, texting, internet, etc.
Examples of Environmental Abuse:

- Financial abuse (stealing money; creating credit card debt; refusing to allow the partner to work, attend school, etc.; withholding money)
- Pet abuse
- Child abuse
- HIV-related abuse
- Status abuse (focused on education, gender identity, sexual orientation, ability, etc.)
- Interfering with partner’s ability to obtain medical or mental health care.
- Breaking objects
- Destroying clothing and other possessions
How HIV Status is Used as a Weapon

• Threats to reveal HIV + status to others to cause harm.

• Sexually humiliating or degrading the victim for having HIV. Telling the victim he is “dirty” or undesirable.

• Isolating the victim on the basis that he poses a threat of infection to others.

• Threatening or refusing to assist the victim when he is sick.

• Use the victim’s HIV + status to justify or excuse the abuser’s violence.
HIV-related Abuse & Violence

• Violence may escalate if the victim refuses to comply with specific demands (demands for specific sexual activities, sex without a condom, sex under the influence of drugs or alcohol, sex work or sex with others, etc.) or attempts to request or have a discussion about safer sex.

• Abusers may rape or sexually assault their victims without condoms or intentionally infect their partners with HIV to keep them from leaving or as punishment.

• Abusers may force their victims to engage in sex with others.
HIV-related Abuse & Violence continued

- Abusers may use the victim’s HIV status as an excuse for going outside the relationship for sex.
- Abusers may use the victim’s HIV status to challenge or gain custody.
- Abusers may prevent victims from seeking or obtaining medical care and social services.
- Abusers may forbid victims from applying for disability or force the victim to use disability benefits to support him or pay for alcohol, drugs, and other expenditures.
- Abusers may destroy medical records, medication, immigration documents, forms of identification, and/or any property or equipment needed by the victim (canes, wheelchairs, etc.)
Types of Intimate Partner Violence

• Situational Abuse (Leeder, 1994): Occurs when a situational event throws the couple into a crisis and does not continue once the crisis is resolved. Situational abuse generally arises in a single argument where one or both partners lash out at each other and can escalate to violence. Not a pattern of control but can occur frequently and can be periodically serious. (Johnson, 1995):

• Chronic Abuse (Leeder, 1994): Violence occurs two or more times with increasingly destructive behavior and may be life-threatening.
Anyone can, and many people do, commit acts or limited acts of aggression whereas fewer become involved in escalating and/or chronic patterns of physical abuse and coercive control.

- **Common Couple Violence (Johnson, 1995):** Occasionally escalates into relatively low level violence (slapping, throwing an object, etc.) during conflict. CCV may also involve abuse and violence revolving around a specific situation or problem (Holt, 2012). May be infrequent, non-injurious often appears to be mutual, and may not create fear. However, it can erupt into severe violence with significant repercussions.

- **Intimate Terrorism (Johnson, 1995):** A general pattern of assaultive, fear-producing control over the partner. Likely to escalate over time, is not as likely to be mutual, is more likely to involve serious injury, and is more common. Context is coercive control. Also known as Patriarchal Terrorism.
Other Types of IPV:

• “Violent resistance” or “self defense”: Abuse and violence perpetrated by victims against their abusive partners.

• “Mutual violence”: Control that occurs when both partners act in an abusive / violent manner, battling for control. In reality, mutual violence is rare and is usually ruled out during comprehensive IPV assessment.
Why Do Victims Stay?

• Lack of resources and support.
• Financial limitations.
• Fear of isolation & being alone.
• Lack of self-esteem / self-worth.
• Fear.
• Traumatic bonding.
• Belief that they are not actually victims.
• Immigration and legal concerns. Fears of deportation.
• Pressure from community, family, and/or friends.
• Safety (75% of all IPV homicide occur when the victim leaves or gains autonomy).
Obstacles to Health and Safety for HIV+ Victims of IPV

• The abuser controls access to financial resources, medical & mental health care, and support systems. As the disease progresses, the victim may become less able to care for himself, more dependent on the abuser, and increasingly trapped in the relationship.

• Leaving the relationship may trigger an array of concerns about failing health, care, financial stability, attractiveness, etc. and may stay in abusive relationships in order to survive / pay for necessities.

• Victims who are HIV+ may be discriminated against in their attempts to get help.

• Victims who are HIV+ may fear that HIV status is more likely to be (or will need to be) disclosed if they reach out for safety-related assistance. (Triple closet)
While heterosexual and LGBT IPV share some similarities, the two are different in numerous ways.

LGBT intimate partner violence, unlike heterosexual battering, ALWAYS occurs within the context of societal anti-LGBT bias (homo/bi/trans phobia), and commonly HIV-related bias, both of which are very powerful control tactics and complicate the identification of abuse, help seeking behaviors, and ultimate ramifications /outcomes.
While LGBT persons experience the cycle of violence similarly to heterosexual persons, the LGBT Cycle of Violence is exacerbated by internalized and institutionalized homophobia, biphobia, transphobia and heterosexism. These present additional challenges to safety and help seeking.
• When internalized anti-LGBT bias increases, it heightens the dynamic of traumatic bonding for both victim and abuser making it more difficult for the victim to seek assistance and easier for the abuser to objectify the victim through projection.

• Projection is the unconscious act of attributing something inside ourselves to someone else. For example, the LGBT abuser projects her/his own feelings of self-hatred (internalized anti-LGBT bias) onto the victim, thereby making it easier to objectify the victim which makes it ultimately easier to abuse her/him.

• The victim, in turn, projects her/his feelings of victimization onto the abuser and subsequently minimizes the abuse. In some cases, internalized anti-LGBT bias and homophobia/biphobia/transphobia (and the projection of it) may be one reason that LGBT defending victims and secondary aggressors use abuse and violence against their abusers.
Alcohol & Intimate Partner Violence

- IPV survivors may turn to drugs and alcohol to cope with and numb the physical and emotional pain of abuse.
- Alcohol abuse among batterers varies from 16% - 79% depending on the study.
- Abusive people with severe alcohol problems are just as likely to abuse their partners when drunk as when sober.
- Abusive people who drink are more likely to inflict serious injuries on their partners than people who do not have a history of substance abuse.
- Substance abusers are more likely to sexually attack their partners and to be violent outside the home.
- Using substances can increase vulnerability to HIV exposure by impairing judgment, coordination, and planning and by decreasing inhibitions.
- Abusers may coerce their partners into using and injecting drugs with them or others as a means of control which can lead to HIV transmission.
Drugs & Intimate Partner Violence

• Drug abuse among batterers ranges from 8 % - 30% based on the study.
• Many drugs are implicated in domestic violence and each has a different physiological effect.
• The drugs most commonly associated with intimate partner violence are marijuana, cocaine, opiates, hallucinogens, and amphetamines.
• With the exception of crystal meth, drugs, alcohol, and substance use does not cause IPV but are co-factors for it.
The Basics of Intervention

• Learn and educate yourself about the dynamics of IPV.
• Develop your comfort level when asking about IPV and screening and assessing for it.
• If and when IPV is disclosed, know your role and make referrals.
• Stay neutral and client-centered.
• Think in small, manageable steps.
• Take care of yourself. Service providers are at risk for secondary victimization / vicarious traumatization.
Screening & Detection of IPV

Screenings should be:

• Conducted as a part of every health and psycho social assessment and routinely regardless of the presence or absence of indicators of abuse.
• Conducted orally as part of a face-to-face health/mental health care encounter.
• Included in written or computer-based questionnaires.
• Direct and nonjudgmental using language that is culturally/linguistically appropriate as well as gender neutral.
• Conducted in private: No partners, relatives, friends, caregivers, or children should be present.
• Confidential: Prior to screening, patients should be informed of reporting requirements and other limits to provider/patient confidentiality.
• Assisted, when needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient’s partner, relatives, friends, caregivers, or children.
Screening & Detection of IPV

WHO?

Screening and initial response should be conducted by a health/mental health care provider who:

• Has been educated about the dynamics of IPV, the safety and autonomy of abused patients, and elements of culturally competent care.
• Has been trained how to ask about abuse, to provide information about IPV as well as community resources, and to intervene with patients experiencing and at risk for IPV.
• Is authorized to document/record in the patient’s medical record.
• Has established a relationship or some trust with the patient.
• Has a clearly defined role in a health/mental health care setting.
Screening & Detection of IPV
WHEN?

• During every new patient encounter (screen for current and past IPV).
• As part of the routine health/mental health history (screen for current and past IPV).
• As part of the standard health/mental health assessment (or at every urgent care encounter).
• During periodic, comprehensive health visits (screen for current IPV).
• During visits for new complaints (screen for current IPV).
• Whenever the patient reports a new intimate relationship (screen for current IPV).
• When signs and symptoms raise concerns or at other times at the provider’s discretion.
Screening & Detection of IPV continued

When should screening NOT occur?

• When the provider cannot secure a private space in which to conduct screening.
• If there are concerns that screening the patient is unsafe for with patient or provider.
• If the provider is unable to secure an appropriate interpreter.
Screening & Detection of IPV continued

If screening does not occur:

• Note in the medical/mental health record that screening was not completed, why it was not completed, and schedule a follow-up appointment.

• Make sure to have posters, safety cards, and patient education materials about IPV available in exam/consulting rooms, waiting areas, restrooms, and on discharge instructions.
Asking about IPV
General to Specific

• “No matter how well couples get along, every couple has disagreements at times. How do you and your partner handle disagreements and conflict?”
• “How do you think your partner/ex-partner might react if you were to tell him that you tested HIV positive?”
• “Do you or your partner have problems managing your anger or have an explosive temper?”
• “Are either you or your partner obsessively jealous?”
• “Do either you or your partner become aggressive when using alcohol or drugs?”
• “Has your partner ever refused to have safe sex?”
• “What happens when you and your partner disagree about what to do sexually?”
• “Are either you or your partner afraid of the other?”
• “Have you or your partner threatened to out the other?”
Asking about IPV continued

• “Have you or your partner monitored the other’s internet activities?”
• “Have you or your partner ever thrown or broken objects?”
• “Have you or your partner called the other hurtful names and made the other feel bad about him/herself?”
• “Have you or your partner ever physically hurt the other?”
• “Have you or your partner ever hit, slapped, kicked, burned, pulled hair, or restrained the other?”
• “There are options and resources available. I would like to refer you to a program that helps people make safety plans and figure out their next steps. Would you like their number? How can you call them safely?”
If/When IPV is Disclosed by the Patient

- Educate about IPV.
- Assess safety and lethality risk.
- Develop immediate safety plan in collaboration with the patient.
- Consult an IPV specialist.
- Report as required by law.
- Follow the Standards of Care.
Standards of Care

• Safety is the guiding force behind all intervention – whether working with survivor or abuser.

• The first step to developing an effective treatment plan is a comprehensive intimate partner violence assessment:

The assessment:
• Determines frequency and severity of abuse.
• Type of abuse (Situational, Common Couples, Intimate Terrorism).
• Differentiates between Victim and Abuser.
• Determines level of potential lethality.
Standards of Care /Assessment Basics

• Determine the context in which the abusive incident(s) occurred as well as the intent of the abuser (primary goal or motivation) and the ultimate effect (who was hurt?).

• Assess if there a power differential in the relationship. If one exists, how do the partners feel about it?

• Determine which partner tends to place blame on others and/or is slow to take responsibility for her/his actions, beliefs, emotions, etc.

• Determine which partner acts out of fear or self-protection more consistently.

• Determine which partner is attempting to systematically assert power and control over his/her partner or whether s/he is attempting to regain personal power.

• Assess for any co-occurring substance abuse problems and/or psychiatric disorders the client may have.

• Do not hesitate to seek consultation with a LGBT domestic violence specialist or program when assessing a LGBT individual or couple.
Standards of Care /Lethality Risks

• Past incidents of physical violence.
• Child and/or pet abuse.
• Suicide threats and/or attempts.
• Threats of violent behavior.
• Violent behavior against non-intimate partners/others.
• Cycle of violence is increasing in frequency and severity.
• The abuser is using alcohol or amphetamines.
• The abuser has access to a gun and other weapons.
Standards of Care/Assessment Outcome

• The primary victim is generally not apt to initiate violence or fight back although s/he may express anger directly or passive-aggressively and/or fight back in self-defense. If engaged in a violent conflict, s/he is interested in disengaging ASAP. Her/his motivation is the attainment of safety.
Standards of Care/Assessment Outcome

• The primary aggressor is the primary initiator of violence and is motivated by the desire to gain and/or maintain power and control over his/her intimate partner or to punish the partner for resisting control. Once engaged in a violent conflict, the primary aggressor has no interest in disengaging.
Standards of Care continued

• Intimate partner violence is always a treatment priority – regardless of other issues or conditions.

• If the client has a substance abuse problem, it should be treated concurrently with the domestic violence.

• Group is the modality of choice for victims and batterers.

• Couples and family counseling is dangerous, can increase violence, and is contraindicated.
Standards of Care continued

• Individual counseling with abusers is dangerous, can increase violence, and is contraindicated.

• Anger management counseling is not an appropriate form of treatment for abusers.

• Referral to health care services to rule out injuries should occur before treatment commences unless immediate crisis intervention is indicated.

• The primary goal when working with survivors is empowerment and safety. Consistent assessment of how one is affecting the other is paramount.

• The primary goal when working with primary aggressors is the development of a danger management plan as well as development of the client’s ability to take responsibility for thoughts/feelings/behaviors/consequences and elimination of patterns of power and control.
ABC’s of IPV Intervention

• Regular and consistent consultation with an IPV specialist is recommended.

• Never suggest that a victim leave an abusive relationship without a realistic and solid safety plan, support, and information. This is dangerous and can put the victim’s life at risk.

• If the client has a psychiatric disorder, or substance abuse problem, these should be treated concurrently with the IPV.

• When working with clients from oppressed populations, it is imperative that identification of and intervention with any form of internalized oppression/racism/homo-bi-transphobia is addressed immediately.
ABC’s continued

• If both abuser and victim are seen at the same agency, care should be taken to make sure that neither is seen on the same day.

• Discuss how you can communicate with one another if need be between sessions. Establish if discretion is necessary when calling. If this has not been discussed with the client, do not leave a message.

• Educate the client about intimate partner violence. Include the definition of it, forms of it, and information about the cycle of violence. Information about the dynamics of power and control in domestic violence can help clients see that violence is part of a larger dynamic rather than a specific response to stress, health related problem, etc.
ABC’s continued

• Be careful not to label stress, anger, substance abuse, co-dependency, illness, HIV or anything else as the reason for the violence. When the client does this, help her/him reframe it.

• Determine what common misconceptions your clients have about domestic violence and educate and challenge those myths with them.

• Understand that abuse is not S/M and S/M is not abuse.

• Be realistic about referrals and prepare the client for them. For example, if you refer a client into shelter, be honest with her/him about the challenges she may encounter.
ABC’s continued

- Exploratory/psychodynamic work is generally not appropriate until abusive behaviors have been eliminated because it can potentially lead to increased levels of acting out.

- Addressing internalized oppression involves exploratory and dynamically oriented work. Until the violence is contained, use CBT techniques to address oppression and focus on self-talk.
IPV Resources

- Shelter-based resources
- Non shelter-based IPV programs & services
- Batterers’ Intervention Programs
- Legal Assistance / Advocacy
Duty-to-Report Requirements

• Health care providers are required to make a report if they provide medical services to a patient whom they suspect is suffering from a physical injury due to a firearm or assaultive or abusive conduct. When two or more providers are present during the exam, only one needs to submit the report.

• Reports should be made to local law enforcement agency that has jurisdiction over the location in which the injury was sustained.

• A telephone report must be made immediately or as soon as practically possible and a written report must be send within two working days.

• Include the name of the injured person, the injured person’s whereabouts, the character and extent of the person’s injuries, and the identity of the person who allegedly inflicted the injury.

• Failure to report is a misdemeanor.

• Document all details in the medical record.
Duty-to-Report Requirements continued

- Mental health practitioners are NOT mandated reporters for intimate partner violence but are required to report child abuse that occurs as a result of IPV or threats under Tarasoff.

- Mental health practitioners are required to report when they learn that a minor has been in the presence of, or has witnessed IPV (CA Penal Code 1170.76).
Important Numbers

STOP Domestic Violence Program / L.A. Gay & Lesbian Center
323-860-5806
domesticviolence@lagaycenter.org

Susan Holt, PsyD, LMFT
323-993-7645
sholt@lagaycenter.org
Important Numbers continued

National Domestic Violence Hotline
800-799-7233

L.A. County Domestic Violence Hotline
800-978-3600

Animal Safety Net
888-527-7722
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