Diane:

Good morning everyone. Welcome everyone to the Intimate Partner Violence Among Hispanic and Latina Populations webinar. This webinar is brought to you by the Northeast Caribbean Prevention Technology Transfer Center. My name is Diana Padilla, and I am your presenter today.

Diane:

So let me just start with the person you may need to connect to. So right here in the bottom to the right is Ms. Patricia Chaple and we affectionately refer to her as Tri. She's the project administrator and is in charge of all the logistical, administrative aspects of any of our events and so the certificates and the copy of slides will come from her. If you needed goals, objectives, and descriptions, and that type of thing, to attain your own credentialing from your state and she'll be able to forward that to you. We as trainers, what we always do, we make sure that she has all that, so she can help address whatever challenges you may have.

Diane:

The gentleman at the bottom of the screen is Clyde Frederick. He is our technologist. He is our tech guru. He is the host of this and every webinar event that we ever have. This gentleman is on with us right now. And if you have some very simple type of technical issues, sometimes you can just text him in the chat box, send a message to the host, and he'll be able to respond and give you an idea or suggestion.

Diane:

My name, you see me here, Diana Padilla. I am a research project manager here at the Northeast Caribbean Prevention Technology Transfer Center, and I provide a lot of technical assistance and implementation support to organizations who want to integrate screening, brief intervention, referral to treatment, or what we refer to as SBIRT and capacity building initiative support around equity and inclusion.

Diane:

One of the things about this topic and why it means a lot to me to present on it, in my past career moves when I was directly servicing the communities I have helped in, I had quite a few clients who presented with these type of issues currently and having had experienced in their past. And so I was able to work with my organizations around developing practices for us as providers.

Diane:

At that time, I was doing a lot of work on HIV and prevention. And this is coming to you from a prevention perspective. And so the HIV network, then at that time had also, had developed a safety plan for providers and we were trained on how to use that and develop safety plans for clients. And I'll tell you more about them more specifically and give you a resource for you to follow up on for yourself through that. And I also work with the legal department and they ended up developing a domestic-violence-specific initiative within their infrastructure to be able to give that specific type of support and advocacy for clients in need, with these situations. So I'm a little familiar with being tasked with having to work around clients and these presenting issues which can be very challenging.

Diane:

I am also looking forward to hearing from you. You have a lot of experience, I imagine, working these types of challenges with some of your consumers that you work with. And so it'd be nice for us to bring it all in into this presentation. So every once in a while, I'm going to be asking you questions and ask your input and please use the chat box. Not just to share resources with one another, but to interact with one another and myself, and we'll make this more of a presentation that we all deliver as opposed to just myself.

Diane:

So here's the disclaimer. The development of these materials is supported by funding by SAMHSA, the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, rather. So the contents are our responsibility and what we do as the N&C TTC is we work off the most current information that we have available.

Diane:

We want to make sure we give you the most innovative practices available, the most best practices, rather. And it comes from experts currently in the field. And so the purposes of these Technology Transfer Centers is to provide support to, and to help you develop more professionally and within your disciplines. And it's also about helping you understand what are the current evidence-based practices, help you build the skills to facilitate it effectively and enhance what you're currently already doing. So this is the TTC umbrella, the SAMHSA funds all the disciplines from an addiction, mental health and prevention perspective.

Diane:

What they will always include in all of our webinars is the importance of being intentional with the words we use. When we see language matters and I'm sure you've seen this, not just in our presentation, but in many other places. And so we want to encourage you to really be intentional in the dialogue you use when you're interacting with your patients and your clients. Anyone who's been in the field for any length of time, may have been used to using a dialogue that includes substance abuse, substance dependence, bipolar persons. And so these terminologies the research has shown, that we've learned over a long period of time. And especially because some of that research also includes specifically the comments and the perspectives from consumers who have been the recipient of our services. And what we've learned is that this is more stigmatic than empowering. And we want to use affirming language to inspire hope and advance people's recovery, and certainly to also promote best practices in the field.

Diane:

So we want to put people first. So we know words have power and this, for anyone who's been in the field for any length of time, again, I would say this is really more of intentional commitment. And so over time you can also change the language and what we do as presenters here, is we do our best to mimic that.

Diane:

So quick question, and this is for the few folks who are on so far. So this is not the easiest topic to discuss. Most of you are professionals, but when we are not in your professional environment, we tend to relax a little bit. And when we're doing the training, when we're having a webinar, when we are doing any kind of workshop, and so sometimes the content can be impactful to you on a personal basis. So if the content were to trigger feelings, visions of past experiences, because the topics sometimes can be... Those feelings and memories are associated with past experiences. It's not just our client or consumer population, but sometimes some of us have witnessed this or have experienced some of this. And so my concern before I go forward, is to ensure that you take care of yourself. I have limitations on what I can do, but I definitely would like to know what can you do? What can you do to take care of yourself? If this topic brings up or triggers, memories and feelings for you during this webinar?

Diane:

Yes. Move away for a moment. Thank you. That's excellent too, Richard. Breathe with my apple watch app. So you have an app. That's great. Step away, deep breathing. The deep breathing part is especially important. Stepping away is also nice and starts to help release a little bit of the anxiety. What you may notice, if you have to take a walk, have something to drink. That's right. Please step away, but please come back. But take the time you need for yourself. What tends to happen when anxiety builds up, when a memory comes up that might be associated with troubling or hardship experience. So whether it's intimate partner violence, whether it was an accident, whether it was anything like that, it can trigger.

Diane:

What happens when trigger comes up is that you start to feel it physically first. And so when you feel the anxiety, if you feel that nervousness, if you feel aware that your heart races a little bit, take a moment to step away. And the breathing is really important. If you can breathe in through your nose and out through your mouth slowly, very, very slowly, as deeply as you can. And do that a few times, you are likely slow down the rapidity of how your internal organs are already functioning. The anxiety builds up the breathing and it goes fast. And we start to feel nervous.

Diane:

So what happens is, with the breathing, you can actually slow that down. If you can slow that down and with your body, then you're likely better able to just calm yourself mentally and just remind yourself that you're here now, that you're in a safe environment, that the past is the past, and this is where you are. So try to do that. And I say that because we're so good when we are with our clients and our patients in that environment. But when we relax a little bit, just to get some information just to improve or to add to our professional development, when we wanted to get those hours for our CASAC or other licensing, we don't realize that we kind of relax a little bit and we're actually more likely to absorb and retain a little bit more at a more vulnerable and deeper level. And so that's why I'm saying this. And because I've had this experience with folks when I've done this in person.

Diane:

So it's really important for us to take care of ourselves. So thank you for that. I like to prepare myself with prayer, utilize the five senses. One thing I can see currently, one thing I can hear, one thing I can taste, one thing I can touch, one thing I can smell. Very good, but do your darnedest to do the best you can for yourselves right now, you are the most important persons here at this webinar. And I'm very mindful of your wellness. That is very important. So thank you for that. And mind you, a lot of the things that we talk about that we can do for ourselves helps with everything. So we can help our clients and consumers with.

Diane:

So here we go, all right, let me start here. So this is a hotline call. So this is what the recording had said, "Barry is controlling and jealous. He works but I don't get to see a dime of it, and I have to go to the food pantry a lot. He spends all of our money on liquor and going to bars with his friends. He won't let me work or leave the house. I don't have my own keys. And he's the worst when he's drunk and beats me. I'm tired of it but I don't dare leave because he'll find me, like he did before. What do I do?" So what are the options for you as a provider? What's your instinct, maybe not so much instinctively, but what does their experience tell you what you can do for this person at the moment? What might you do? What might you say to her? Okay. Call the hotline.

Diane:

Okay. Offer to connect to a DV shelter, that's good. Okay. Validate in a safety plan. If possible, go online. If she has somewhere else safe she can go. Prepare a Go Bag. That's all part of safety plan. Right now she's doing a hotline call and safety is always the first thing we do think about. Is she safe right now at the moment? And so this is good. This is great. So you want to make sure that you listen to her, that you validate what she's saying, that she felt like she has been heard and that you're there. It's important for folks, when they call the hotline, to understand that someone is there to support them, if and when they need.

Diane:

Many times, when someone calls a hotline, they're not necessarily ready to do anything of what options we might give them at that moment, but it's important to establish, to really initiate that rapport. And so, yes, safety is a big deal. Are they safe right now? Can they even talk? Is this safe for them to talk to you right now? So start to understand and learn who they are. So this is just an idea. This is just one of many types of situations that you probably have come across or are likely to. So thanks for those suggestions. Provide info to obtain an order of protection. And I know that would eventually be part of it. Initially when she first is asking you what to do, is you want to address her safety.

Diane:

So let's go on to understand some of the dynamics involved here, which better informs what we can do. So this is a little graphic, but I just wanted to show you, from a prevention perspective, prevention works on three different levels. And it's important for us to understand what we can and can't do within the capacity of our work. In primary prevention, preventing violence may involve aiming and changing attitudes, is any action or strategy or policy that prevents intimate partner violence from initially occurring. So primary prevention seeks to reduce the overall likelihood that anyone will become a victim or perpetrator by creating conditions that make violence less likely to happen. And so preventing first-time perpetration and first-time victimization is part of primary prevention.

Diane:

Secondary prevention is preventing the recurrence. And so the recurrence being that you want to maybe address screening programs, to address risk factors, understand the other mitigating factors, such as, alcohol use. The suggestion of being able to be an advocate, the ability of resources for advocacy and order of protections as Hilda has mentioned in the chat. These types of things are secondary prevention.

Diane:

Tertiary. It's when damage has already been done and you want to treat the problems that result from violence. Getting the medical care. And instill understanding of the severity of the problem to the degree that it is. Safety planning at that point, even if the safety planning of the secondary may or may not have been offered then. So tertiary has to do with not letting it be final. So prevent death and disability, treat problems that result, provide mental health services, legal, what is the safe housing, legal advocacy, and more. And we'll talk a little bit more about that.

Diane:

So primary prevention. Let's look at what we've talking about here. So one of the interesting things, when we first started to put this together was that these two terms are being used interchangeably, domestic violence versus intimate partner violence on the different websites who specialize in this particular topic. This might merit, it probably makes sense just to give you a little history of where these terms came from.

Diane:

And so a lot of folks are more familiar with the term domestic violence. The traditional view of domestic violence was really focused on in a relationship. And so it focused on a crime of abuse involving two individuals, and usually in a heterosexual marriage situation. And typically the abuser was the husband, and wife was typically the victim. And that's not to say that men are not victimized by these situations, but the prevalence is amongst the female gender.

Diane:

So the origin of the domestic violence, where the abusive behavior was viewed as a form of violence that existed within a domestic relationship. A domestic relationship was typically the married couple. But in the 70s, women's rights groups evolved and advocated for victims. And a lot of work, a lot of efforts and energies were spent on that and it resulted in shelters being made available for victims, people who had been victimized by domestic violence. And the shelters themselves started to provide opportunities for research and increasing awareness in the general population, not just in behavioral health fields. And so Congress ended up passing the Violence Against Women Act. And then the legislation strengthened those laws by specifically identifying violence against women as a crime, and then need more focused attention. And that started to happen in more local entities in the state levels. Societal views expanded to better understand these types of biases that exist within relationships, as well as the reality that the rules of the abuse and the victims are not gender-specific, which is what I was trying to say.

Diane:

We see a lot of males who are victims of intimate partner violence. The LGBT community has their own challenges also, in terms of intimate partner violence. The transgender community has the highest rates of violence against them. Violence and homicide against them. So it helps us to be mindful and knowledgeable and be able to share the information with our communities whenever possible. So the term intimate partner violence was introduced to encompass a broader understanding of violence in relationships. And so, even though it's used interchangeably, domestic violence can be anyone within a family unit or any very well-known person close to the family. And so we moved away from the old view that abusive violence only occurs in a relationship or partner relationships like back in the 30s, 40s, and 50s. And so that was a particular perspective.

Diane:

And at that time, it wasn't even as much as a romantic relationship as it was a business arrangement. And so the concepts have evolved, society's perspectives have evolved. And so we do acknowledge that abuse can happen in any type of personal intimate relationship. And that, hence we have this newer term, intimate partner violence. And it doesn't matter the sexual orientation, whether or not a person is married, or their gender. The term doesn't assign roles of the abuser. But we will talk in this webinar, how it specifically speaks to women. And more specifically within the Hispanic Latinx population.

Diane:

So intimate partner violence describes different types of violence, physical violence, sexual, stalking, psychological. But we also recognize that it occurs across age differences, ethnics, gender, economic lines. And so there is there's no picture of what indicates that a person is more likely to become victimized by intimate partner violence. So we do know that it occurs across all kinds of dynamics, all kinds of intersections. And so whether it's women, cisgender couples or same-sex couples. So what's reported is about 1 in 4 women, nearly 1 in 10 men have experienced contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime. And so over 43 million women and 38 million men experienced psychological aggression by an intimate partner in their lifetime. This is what's been self-reported. This is what has been documented.

Diane:

And despite these numbers that seem to really present a good case, an alarming case for this type of situation, I will let you know, because a major part of my background is the work I do in research. And I will tell you that all these numbers are very under-reported. They're very modest compared to what actually happens. There are a lot of folks who do not report, so let's continue on. So we start to understand some of the factors that will influence whether or not a person even reports, let alone seeks help.

Diane:

So in the news, and this I'm going to want to bring up to date. Part of why we are here with the specific topic. So during the pandemic the rates of intimate partner violence situations just increased very much. And I know our main focus was trying to keep safe and try to keep working within safe guidelines and even bringing services to our communities in a safe manner. And there wasn't a lot of focus on a lot of other things other than what was pandemic-specific. But all around the world, domestic violence and intimate partner violence had increased to levels that we hadn't seen in awhile. And so I just wanted to share with you, like there was one report about a 12-year-old girl that was allegedly raped in Peru last year, she's the youngest victim of a pandemic in the shadow of gender violence, as we know, from what has been reported from what we know.

Diane:

So many things, a couple of situations that may be more familiar to you. This was Andrea Ruiz, 35, who was denied a restraining order. Despite the fact that her abuse was described in one of the recordings. This was a journalist that gathered this information, despite the fact that they had access to the recording. And she was very descriptive in the different things that he did. And that was part of what she described to the courts. She was trying to get him arrested, and they just denied her charges. And 30 days later, he found her and murdered her. And this was just a couple of months ago.

Diane:

And so Keishla Marlen Rodriguez, 27. This one has had a lot of notoriety because she was killed by the boxer lover, Felix Verdejo Sanchez, a young man with a very promising career in Puerto Rico. And these two situations really highlight the lack of support, the lack of systems and availability of support for women who are going through these issues in Puerto Rico. One of the things I will say, and one of the reasons why I mentioned Puerto Rico is because they're out neighbor. They're close, there's no restriction in terms of travel.

Diane:

And so a lot of the clients and patients that we tend to see in our programs are from our neighboring states and areas. And so Puerto Rico has never fully recovered since Hurricane Maria. And so has been hit with so many different ways and has pretty much regressed in terms of being able to have appropriate or adequate systems in place to support communities. And so the rates of gender violence amongst the Puerto Rico community really increased. So I wanted to include that here, because we might see some of these folks.

Diane:

On the crowded streets of Panama City, a woman approached the hospital, clutching her purse. This is something I snatched out of an article. Before she reached the entrance, two police officers blocked her path. And they asked her where she was going that day in Panama. And because of the restrictions that were in place, only women were allowed outside. The woman, who is transgender, asked not to be identified. She was fearing for her safety. Apparently that's what one of the officers says. And so while she took a deep breath and she explained she had a doctor's appointment. The officers interrogated her and denied her entrance. Apparently, this is how she reported it to a human rights group later on. And the second officer is a neighbor, he knows her. He hit her and did not allow her to follow through on her appointment. So this is happening, and this is very specific to Hispanic, Latinx.

Diane:

I'm not saying... It's going on in other countries and other communities. Our focus today is on the Latinx, Hispanic communities. These are specific situations that really starts to bring the light, make the case as to why is it so important for us to address this. So IPV or intimate partner violence in Hispanic, Latinx communities tend to be 4 out of 10 say that they have been called by offensive names, or are told to return to their country of origin, just because they speak Spanish in public, or have suffered some type of discrimination or unfair treatment for being Hispanic. Now also, let's just to bring another layer of reality here. The current pandemic, though we've been dealing in now into a second year, and in the last several years, with the pandemic and the racial oppression in this country, it has really made it much more difficult for a Hispanic or Latinx person or a person of a diverse background to seek services. Particularly if they're challenged with limited resources and or knowledge of those resources. And when you have these extra stresses in place, it makes it much more difficult for an individual to seek help.

Diane:

So 24% of Hispanics say someone has discriminated against or treated them unfairly because of their background. And this is not very surprising, is it? We've been hearing it. We've been seeing it in the news. We've been hearing it and learning it from our research. This is a quick map of the domestic violence rates in Puerto Rico. And so we have this all across the island, you see all these reported cases. In the United States, the rates had gone up around a good 30% when the pandemic first hit. And so what we see here is just all across the board and how the different communities of re racial and ethnic backgrounds have rates of violence against them.

Diane:

And so here's another hotline call. And I want you to tell me what you think about this. The woman's partner had never threatened her with a gun before, but when she told him she had to go to work during the COVID-19 outbreak, he refused to let her, the woman told her partner that she had to go if she wanted to keep her job. He then proceeded to take out his gun.

Diane:

He then proceeded to take out his gun and began to clean it. What's your take on that?

Diane:

What is your take on that? Yes. Yes he's making threatening behavior. He's making an indirect threat. I'm not sure Hilda I think that that was, it probably is. I just didn't have the numbers available right now. Thank you. But I think I'll update that. Threatening behavior, he's making an indirect threat. He took his gun out and began to clean it. There's no report. There's no added information saying he said anything.

Diane:

Homicidal types of threats, dangerous situation. Yes. So, a person who is not allowed, who's being controlled to the point that she can't go on, she can't keep her job, and her own anxiety and all this going on. Then he takes out a gun and he begins to clean it can be very traumatizing, very terrorizing, to be even more specific. That is a threat.

Diane:

Confinement risks, and it brings us to this. There are different anxieties going on, financial anxieties, close quarters, health concerns. All bring extra stress into the home and are associated with a higher risk of abuse. Add the skyrocketing gun sales during the pandemic that increase, I think it was more than 50%. I think it was more, no, I think it was higher than that. I think it was 41%, that's what it was. Think about also the fact that there were job losses, and statewide shelter and place restrictions. So health resources for medications and pharmacy, urgent care, all of that restricted...folks had legitimate reasons to want to go to the emergency room and many were turned away because they were so busy. Hospitals were so overwhelmed with folks who needed the bed for COVID patients.

Diane:

So the recipe for disaster was widespread economic strain, a surge in firearm sales, social distancing. Had grave consequences for persons who were victimized by intimate partner violence. Yes. Kids, kids at home. That's right.

Diane:

Let's talk about some types of abuse. How about you folks tell me? Because you already know some of this. Why don't you tell me the different types of abuse? Write it in your chat box and let's pick up on some of them. Just so we can recognize that.

Diane:

Okay. You're talking about kids at home, pedophilia, the sexual abuse to children. Let's talk about intimate partner abuse, very specifically. Okay, verbal. Mental, verbal, emotional, right? Physical, emotional, sexual, verbal. Those are the ones that kind of pop into our mind. Because that's what we know. That's what we're familiar with. That's what many, many of our folks present with, matter of fact, if you work in the addiction field, 90% of our folks, a good 90% of them have had issues with trauma. Many are based on sexual and physical abuse. Psychological, thank you for saying that. Manipulation gas lighting, yeah. There's different kinds of abuse. Thank you. I have some here and these speak to all the...cultural abuse? How do you mean by that? Spiritual abuse.

Diane:

I like that, culture abuse. Add in the chat box some more elaborating information about cultural abuse. I've not heard it that way, but, I am very open to that. Spiritual abuse. Yes, a lot of times you stop a person from, the very things that mean a lot to them that helps them spiritually or religiously. The stalking. Yes. So I have some here.

Diane:

The taking or diminishing of one's spark. Oh that is definitely part of this. So let me just go through this very quickly. Because you know some of this, physical abuse is any intentional and unwanted contact with you or something close to your body. If the person being victimized is...someone is doing this to them. Its abusive behavior that does not cause pain or even leave a bruise, but it's still unhealthy. It doesn't always have to do that.

Diane:

Then you also have...oh, I see what you mean. Different culture permits, different kinds of abuse as the norm. That's a perspective on our parts. We have a Western perspective where we have certain ways of how we define abuse and from a cultural perspective, it may be a completely different way of what they think abuse is, what is okay. Within the parameters of what is acceptable and what's not acceptable in that community. I get that. Thank you.

Diane:

Something close to your body. Well, let's put it like this. Say you're forced to stand beside a very, very hot stove. Or, someone is terrorizing you with...say, a lit cigarette, and the closer it gets to your body. Yeah, like that. Those kinds of things. That's going to have a physical impact if they actually touch your body, but coming close to it also has an impact. There's a terrorizing aspect to it.

Diane:

Yes. The person punches the wall next to your head. That's a really good example, unfortunately. Let me go through some more. Sexual abuse refers to any action that pressures or coerces someone to do something they don't want to do. Anything physical that they don't want to do.

Diane:

But it also goes into refusing to use condoms. We don't always think about that. We think about someone assaulting someone sexually, but it's even more than that. Unfortunately. Refusing to use condoms, especially with someone who may have HIV or an STI. Restricting someone's access to birth control. One person controlling that and the person is not allowed to control it for themselves. Sexual contact with someone who's very drunk, unconscious. Whether or not the individual is able to clearly say yes or no, it's still a sexual assault.

Diane:

Emotional abuse is threatening a partner, his or her possessions or loved ones, or harming a partner's sense of self-worth to gain and maintain control of the relationship. I had mentioned to you that I have worked with women who were victimized by intimate partner violence. I have one lady who...told me the story of how she was using substances before she came into treatment. I've also worked in addiction treatment. Before she came into treatment and part of her lifestyle was in using drugs she would get away from her abusive partner. One time he put the word out in an area where she usually hung out around and said that her son was dead. She only had her younger boy and she hadn't seen him in a while because she was actually actively using to a very extent degree.

Diane:

He tried to emotionally bring her out and isolate, find her because he was having a hard time. He eventually found her. He always did find her every time she tried to keep a distance. She realized, she felt it inside that her son was not dead, but that he was trying to use that to bring her out in the open. That type of emotional abuse, that's just one example of a great many. Examples include, but are not limited to name calling, intimidation, isolating a partner from friends and family.

Diane:

What we do understand is...wouldn't all abuse be considered emotional? It would, but you also want to, from a clinical perspective, you want to be able to understand the impact. All of these intersect, all of these overlap, all of these to different degrees are having an impact on the given individual. That's important to know. Verbal abuses, we already talked about. Sometimes you hear folks when they speak to each other, just the difference between someone having a quick argument, and the difference between a person actually being demeaning, derogatory, and offensive and calling somebody things like, "How could you be so stupid? Don't you ever speak while I'm talking." Especially in front of people where it can be humiliating, but it's not always there.

Diane:

A lot of folks who are abusers tend to present very well in front of the public, in front of community and tend to do a lot of this out of sight. Economic can be to limit a person's access to assets or conceal information. It could be that one of the persons, or both persons are working, but one controls the money for the other person. Maybe give them an allowance, monitor what they buy. Just ensure that they only buy what they're told to buy. Using the partners social security. Maybe they have good credit and forging their signature to gain property. All of that is economic abuse.

Diane:

So digital is something we also do not necessarily think about too much. These days, we do now, right? Because of the pandemic? Digital abuse is the use of technology such as texting, social networking, to bully or harass or stalk. Stalking happens a lot from a digital perspective. Nearly half of all young people, 14 to 24 report that they have been electronically harassed. 40% of reported incidences, digital dating abuse, so we do have a huge issue with that and teen dating. Sometimes, and it's a smaller percentage, 11% their naked pictures have been shared out in the internet. Once something goes on the internet, you can never get it back. There's always a digital footprint.

Diane:

Thinking about dictating, who can, and who cannot be your social media friends. Checking a person's texts. Watching them when they are on any type of electronic, and either if following up behind them or controlling, putting digital controls within certain processes that the person being victimized tends to utilize.

Diane:

All of these things are considered...yeah, constantly over your shoulder when your phone goes off. Who's calling you? Why is this person calling you? Yes, digital.

Diane:

Psychological is any act including confinement, isolation, verbal assaults, humiliation, infantilization, intimidation, or any other treatment which diminishes a sense of identity, dignity, and self-worth. I want you to consider, this is the impact of a lot of these other particular types of abuse in any form, in any level, to any degree. Just imagine that for any given person over a long period of time, that consistency, that chronic-ness of that type of existence. Impacts the person being victimized. Can impact them in such a debilitating way that it really limits their capacities and really does huge damage. Which, we'll talk about now.

Diane:

Making them think there's something wrong with them when there's nothing wrong. Sometimes, I had a client who...she said, whenever she got home, he would ask her where is a particular item? She would be so sure that she would leave at certain places and, the item would not be where she left it. After a while she started to second guess herself, she started to be unsure if she remembered where she would put things. Substance use was not part of her life. What he would do is take that as an opportunity, when he didn't find something, to beat on her. So things like that, it's the psychological impact of the types of abuse, there are opportunistic situations for abusers and they maximize on that.

Diane:

It's all about power and control. Physical, sexual, no matter what kind of balance it is, or any type of overlapping, or all the different types of abuse that does happen. It's all about power and control. There is...for the person it's about them always thinking that they're entitled to do this and have the person doing exactly what they want, how they want.

Diane:

I also wanted to make sure I include the power and control for the LGBT community, because, with the challenges with that community can include the transphobia, homophobia, and how folks might use this and how abusers have used this to control their partners. I remember back in the days when I was working in HIV prevention and how many times I had folks come in and tell me about how their partners...they were happy to be there because they would feel like they can connect with other people. For the most part, they're usually not allowed to do much. Sometimes their HIV medications were taken from them. Things like that. Power and control within the LGBT community, slightly more expanded when specific to the psychosocial issues that happen within these groups.

Diane:

You folks tell me, I've been speaking for a little bit. They're afraid to change, fear reprisal. Yes. Codependency. Okay.

Diane:

What other reasons why somebody would stay? Financial dependency and low self-esteem! You put in just the right debilitating factors within a particular framework, and you actually have the opportunity to understand why someone might stay. If they have limited resources or limited knowledge. Maybe afraid of being alone, that's true. The cycle of DV, that's really important because the cycle of abuse is very...it's not just that it's impactful. That coercive-ness, that traumatic impact over time really provides the part of the control for the person, while debilitating one individual the other abuser is actually being able to pull the strings.

Diane:

At least he loves me, lack of knowledge of available resources. That's correct.

Diane:

Let me just show you what I have. Yes. Mental health issues, that's right. Fear of leaving, or losing custody of the kids.

Diane:

Sometimes if you have limited resources. Particularly for individuals or abusers who present themselves very well to the public. It would be hard for somebody's word, if they're not working or have the appropriate resources to support their children, and the other person has the capacity already established and all of that. It may make it hard for some folks to be able to leave if they think they're going to lose custody of their kids. You already mentioned low self-esteem and...source of income! Sometimes the person being victimized may not have a good source of income. It makes a difference whether you can actually provide for a roof over your family's head and make sure that they have nutrition, than to just have a job that doesn't necessarily pay the bills. It can just add to the budget.

Diane:

A victim's reasons for staying with their abusers, they can be very complex and most cases they're based on the reality that their abuser will probably follow through with the threats they've used to keep them trapped in first place. The abuser will hurt them or kill them, or hurt the kids. They will win custody or they'll harm the pets. So they'll ruin their victim financially. This list can be so much longer.

Diane:

Traumatic impact, we're going to talk about that. A recent study of intimate partner violence homicides found 20% of homicide victims were not domestic violence victims themselves, but family members, friends, neighbors, persons who intervened and law enforcement responded over bystanders. It makes it hard to get the kind of help that one person may need.

Diane:

Here is the cycle of abuse. Here's the honeymoon period. I want you to see on top. This tends to be the pattern in most situations where abuse is present. So, honeymoon period, then the tension builds and then there's an explosion. Let's talk about this for a second.

Diane:

I had a client, and what she told me was this. She explains how...we were having a woman's group and just sharing. It was designed to let folks know about what domestic; at that time we using domestic violence, the title, the topic, the reference. We were talking about the dynamics and factors that actually outline a domestic violence situation.

Diane:

One of the girls shared her personal information. One of the things that happened to her, she was in treatment at the time, but when she wasn't in treatment. What her guy would do is when she first met him, everything was nice, and this kind of played out. But what happens after a while? It was, he would be nice to her and they would have a nice period where they seemed to be happy. The period lasts for maybe a few days. If he asked her or told her to do something and she wouldn't do it, he can get very angry. So, at one time when she was still using, she was still with him. She was supposed to hustle up some money. It was supposedly to get high. He gave her a time limit, it was something like 15 or 20 minutes, or 30 minutes, something like that. She was not able to get money for the drugs, for what he wanted. So he went and he got her from where she was at, and he decided, he said, "Come on, we're going to go home."

Diane:

What she said was essentially to leave her, and she said, she's not ready to go back. She's still going to drive. He had told her, "No, no, no. Don't say anything. Don't say anything. We're just gonna to walk home." He walked, he didn't want her to speak, and they walked to the house, and he made sure they didn't rush. They walked slowly back to the apartment.

Diane:

At that time, what he would do. He always wore a baseball hat. He would turn it around. When he turned it around and started to walk back slowly, she felt the terror building up. Here, the tension was building because she knew that by the time they get to the apartment, she was going to get a beating, and that's where the explosion happened. By the time they got to the apartment, she got a beating, because she didn't do what she was told.

Diane:

Two days later, he starts to apologize. He's sorry, he loves her. He can't live without her. Please don't leave him. All of that came through. This cycle was part of her active addiction. This cycle happened to her over and over and over and over again.

Diane:

This tends to be a pattern that research has shown, that in some way, somehow, with certain opportunities, certain details of different persons who've been victimized, the different details of their life. This cycle tends to happen. The explosion would happen after the terrorizing, the building up of the tension. It increases the terror. Then there's an explosion, which is the beating or the abuse or the...because it's not always physical. Then there's the honeymoon period where the person comes back and say, "No, I'm sorry. I love you." They'll cry, whatever.

Diane:

Yes, not surprising, deeply embedded. This is interesting. This is part of what research has been showing for a long time. The details may be different, but imagine what it does to folks who have been victimized and that terror and that traumatic impact on an individual over time.

Diane:

Part of this is the narcissistic personality, and in mental health what we do know is that abusive people believe that they are entitled. To exercise that type of power and control over another individual. It's their feelings and their wellbeing is the most important thing, and the only important thing, many times, in situations. Abusive tactics are justified in their mind to dismantle equality and make their partners feel less valuable, and worthy of respect and relationships. What's interesting is that, what is available for persons who do abuse? Are cognitive behavioral therapy.

Diane:

I have not seen, and I need to probably check what more recent literature is saying. But I have not seen any conclusive intervention that changes a person's sense of entitlement, where they completely stopped abusing. What has been helpful is that abusers can get into programs where cognitive behavior, when it's consistent, can arrest their behavior. It's not necessarily gone away, but they can do certain things to not do that anymore.

Diane:

It's really interesting, the dynamics there. There's been more effort actually expended on the people who have been victimized. So IPV are physical symptoms. These are some of the things that we might want to be mindful of when we're working with our client population. Sometimes when headaches are presenting, insomnia, chronic pain, choking sensations, hyperventilation, gastrointestinal symptoms, all of these are...pelvic pain. All of these part of the result of physical symptoms of physical, not just physical, but also different types of abuses.

Diane:

The demeaning behavior, derogatory statements, the consistency of depleting that self-esteem. A lot of times what cognitively an individual will internalize or absorb, they can also express somatically. Traumatic brain injury, TBI, non-fatal strangulation, are also physical symptoms of IPV, and they're often unrecognized. They're unrecognized, if we're not asking the questions, but it can lead to significant neurological sequelae.

Diane:

Coping with IPV, let me tell you about another case that we had. That's good, DBT. That's true.

Diane:

A decade ago, Christina Love was dropped off at a domestic violence shelter in Anchorage, and this is in Alaska. So, fearing her partner might attempt to kill her. There was alcohol on her breath, so the shelter turned her away. Feeling like she had nowhere else to go, she went right back to her partner who she says sexually assaulted her that night. Another time her partner had hit her in the face with a two-by-four and her jaw had to be wired shut. Police had brought her to the shelter, but they wouldn't take her.

Diane:

Again, she went back to her partner. She had no other place to go. Christina Love said that she had been kicked out of six shelters over the years for substance related offenses. One of the things that many shelters do require very often is that a person not be using.

Diane:

I know that has to do with the safety of other persons in the shelter. It maybe part of the criteria, to be able to be at the shelter. But coping with IPV, substance use is often that manner of dealing. Is that manner of being able to exist despite intimate partner violence situations. She was like between a rock and a hard place. Every time she'd go back home, she would be assaulted again. She eventually found a place where, and it was an addiction treatment facility. She went into a residential program that had domestic violence resources.

Diane:

What they did was they helped her relocate, eventually. She had a confidential...when you're in residential, you can have confidentiality. No one needs to know where you're at.

Diane:

That gave her enough of an opportunity for the counselors and the other professionals there to help her, not just psychologically, but with resources. Eventually she ended up in another place away. She was empowered. She was educated, and she was able to start again. These days, even though she spent a lot of time in and out of shelters, today she teaches people how to help improve those programs services. The systems that are supposed to be designed to help folks who have been victimized sometimes do more harm than good. What she tries to do is, she helps with programs to understand how they can be dehumanizing at times and more depletive just at the times when victims need help.

Diane:

She's been able to actually turn around and use that energy to help inform programs, how they can be more effective, which is really great.

Diane:

The IPV, intimate partner violence, mental health, and substance use. High rates of DV among women accessing substance use disorder treatment tend to be anywhere between 47% and 90%. Folks who have been...and this was a couple of years ago. Within the last year, up to 67% of persons accessing substance use disorder treatment have reported having DV in their past.

Diane:

There are high rates of intimate partner violence, amongst women who access mental health treatment. What we want to understand is that domestic violence can have traumatic mental health and substance use affects, substance use very often is the buffer. It is not just the way to deal, but it's the buffer for it not to have as intense of an impact. But there's a lot of things that happens to the brain. A lot of things happen to the person themselves, while they're using substances. This is important to understand is that, sometimes what happens is that existing mental health issues can be exacerbated or it can be

Diane:

So health issues can be exacerbated or it can be a pathway to major depressive disorder, generalized anxiety disorder, and then that has other subcategories as well. Post-traumatic stress disorder we are used to associating that with PTSD, with partner violence more obviously because of the detrimental impact and other substance use and related disorders. For instance, your substance use or your depression symptoms and disorders. I mentioned about anxiety symptoms, impairment in relational, social and other major life areas, increase risks for mental illness, increases symptoms severity. So when you think about that, we mentioned already about gastric conditions or sleep disorders. So there's an array of different types of impacts.

Diane:

So the symptoms of PTSD tend to be fear and anxiety, shame, internalized guilt, nightmares and memories, hyper vigilance. And this has a lot to do with, actually more specific to these partner violence situations, but symptoms tend to start early, but within three months for it to be PTSD, it typically happens within three months and occurs chronically.

Diane:

It can come up even years later. Symptoms might last more than a month. And it's a fear that's generally so severe that it's very hard for a person to either a sustain a job or do things like maybe just take care of themselves. And so to be diagnosed with PTSD, you have to have at least one month of experiencing symptoms, avoidance symptoms or arousal, reactivity symptoms. And so, and that's what you have. We have our diagnostic instruments in order to be able to diagnose that appropriately and come up with the appropriate recommended treatment or recommend the appropriate treatment rather. And so yes, recurring nightmares and more and more, a lot of times there's a lot of this disassociativeness? So these are things that some of these, we can see as behavioral indicators when we are working with patients and clients that we're getting to know and after a while, they start to act differently. We see some of these symptoms, this is worth really exploring.

Diane:

And so one of the things I wanted to share with you, because this, I thought it was, I use this when my trauma informed training says, well, chronic trauma and trauma over time with someone who has been in a debilitating situation like partner violence. What we don't realize is that that folks, the uninformed public, does not understand some of these dynamics. Trauma does is very similar. This has a very extensive and very similar impact that crime, the substance use disorders have, what happens is the hippocampus shrinks. The hippocampus is in the middle of the brain. It's in the midbrain it's called the Limbic system. That's where memories are retained, the associated feelings of those memories and experiences they're retained there.

Diane:

And so what happens is chronically, what happens to a person's brain, it can shrink over time. And when some folks are having flashbacks, sometimes that part is so compromised that the person cannot distinguish between the past and present. And so the increased activity in the amygdala that usually helps a person process emotions or situations they're linked, they're associated with fear responses. And so that is almost, not necessarily relived, but certainly re-experienced to a certain degree. So that's that triggering, that re-traumatization process that happens. And so what is really important, while this is going on, the prefrontal cortex tends to shrink and this is the part that we need to be able to make informed decision decisions, to be able to process the different aspects of any given situation. And so that helps us regulate negative emotion, but it tends to shrink also.

Diane:

So it's, all these functions are compromised, can be compromised to a degree where very specific clinical treatments are needed. And sometimes the changes in the brain chemistry are the reasons why for some folks, for some folks, folks with very, very severe levels of PTSD need EMDR and CBT to fully reverse the effects.

Diane:

And so all the vulnerabilities that do occur, people experiencing mental health and substance use disorder, they place individuals at greater risk of being controlled. And so when there are other risk factors that increase are present, it just presents more of an opportunity for an abuser. So stigma associated with substance use and mental illness also contributes to the effectiveness of abusive fast tactics.

Diane:

So let me talk about secondary prevention unit in the Hispanic, Latinx community. I want to make sure that I cover everything within the time that we have. And so one of the things approximately one in three Latinas have experienced physical violence by intimate partner in their lifetime, 50% do not report. Depression and psychological distress is strongly associated with IPV, and they are unique contextual issues when it comes to IPV among the Hispanic women, what we want to understand as we can factor in and understand some of those characteristics within the culture, we can actually use that to engage or reframe within our messages and our supportive interactions with our client community. So due to barriers like anti-immigration laws, Latinas are half as likely to report abuse versus survivors from other ethnic and racial groups.

Diane:

And so if, and think about it, if ethnic individuals, if some Latinos or Latinx are living in poor neighborhoods, they may experience multiple risk factors for depression, including unemployment poverty, and think again, think about the context or the layer that depends on and that also includes. And so the frequent changes in residences, that just a multitude of, are a myriad of different, stressful life events. And so Mexican American women who report high levels of spirituality also report higher levels of resilience and coping with intimate partner violence. So that's not to speak to how sometimes these cultural characteristics are opportunities for us to integrate and how we support Hispanic and Latina women who are victimized by intimate partner violence.

Diane:

So every person has their own philosophy, they speak on how they are, how they live, every single person on this platform. Every single person in the world has their own cultural perspective, has their own... And I think about culture, as cultural perspectives, as culture express. Who you are, how you live, what you, what you believe in, how you speak is your culture express. And so in that there's opportunities, some of the norms within characteristics within the community that you, that a person identifies with, they can be adhered to by that individual at different levels to certain degrees.

Diane:

So understanding what those norms are for them can influence how the experience will be acted to intimate partner violence or domestic violence. And so they also provide us opportunities to engage them. So some of them are familiar characteristics, and this was identified years ago, more than 25 years ago.

Diane:

I read the first research that specifically labeled characteristics within Hispanic, Latino, Latinx communities, that was in the late nineties, I'm definitely dating myself. And so these terms come up and they be, and they speak to certain ways of being in certain ways of acting, certain ways of speaking. And so these are opportunities for us as providers. So Familismo refers to the importance of the family and the members who, and to its members and who is identified as family. And so understanding what those, what that unit is, how it's defined by that individual is very important and understanding the importance of keeping our family together. And when you spoke about it, you said it earlier, you said it earlier, that there are times where somebody won't leave a situation or won't do too much of a situation because they are more worried about the kids or want to keep the family together. So let's think about that.

Diane:

I see. If someone was in an abusive relationship for about six to nine months, they would experience the same of someone who has been in abusive relationship for years.

Diane:

Oh, the mental health issues that they experienced the same. That's interesting. I know that a lot of it has to do with individuals' capacities and whatever coping styles they have and whatever interventions you can also provide. So thank you, Mary.

Diane:

Personalism, let me go through that. It's about how one is perceived by another person. It's not just how you are, how you are looked, how you can face off with someone else, what you look like, how you approach someone. But it's actually how you're perceived by your community. And there are many members and there are many persons who do abuse, who do present to the community in a way where it's hard to think of they are anything but a nice person or a responsible individual.

Diane:

So within this community though, it's very specific to that it's also, it's all about approachability, how you greet someone, how you interact with them. So respect there's also areas of behavior where what's the appropriate form of greeting. Perhaps it's not, it's an older person. And if you ask them, always ask, always ask, no matter what cultural background a person is from, you always want to ask how they would like to be addressed. Don't, we don't... We only know we do get informed about characteristic trends within communities, but that's just to help guide our eliciting of information. It's not templated.

Diane:

And so gender role expectations. This also has something to do with why some folks might consider allowing a situation to play itself out, trying to keep the hope alive, that it will change.

Diane:

So Machismo is expected for, as is a term that has been used that really was evolved from the Hispanic, Latino populations, but has transcended all cultures and Western perspective has really taken a liking to Machismo for the last many, many, many years. And so Machismo underscores male responsibilities, including this, the thing about protecting the family, being the head of the family.

Diane:

But then you also have other things like with women in Hispanic, Latino populations in Marianism is the idea that the woman can be self-sacrificing, particularly if she has a religious beliefs how she's supposed to be submissive. She's not necessarily boss of the relationship, she is supposed to be complacent and follow through on her part, her role in the relationship or the family unit.

Diane:

And feminism has a lot to do within this culture. Feminism has to do with a woman being a head of the household. And that means that she's in charge of keeping the house clean, keeping the food on the table, taking those kids to school, making sure that homework is done, doing that laundry, taking them to the doctors, everything that has to do with the household.

Diane:

And so while she's doing that and what she is trying to work things out or exist within a hurtful situation, and maybe thinking about her own philosophies and her own belief systems, that might be opportunities for us to tap into as providers and be able to engage in a conversation that might actually be supportive. So religion can prevent victims from using services because of the quote unquote "sanctity of marriage" and preclude steps that may result in divorce or separation. But it's that sanctity of marriage that you can actually reframe in a conversation. And so acculturation is also one thing we cannot, nothing is templated any group. And so gender-based violence is less prevalent among those with strong ties to traditional Latino cultural values and orientation, but it's associated with poor mental health.

Diane:

Immigration is a very, very interesting thing. It's very hard to consider immigration is certainly should be part of the power and control wheel. Because what we do know is that if someone is undocumented and another individual is, then what can happen is that that is the very leverage that the abuser may have. And so it can be providing even more limitations in the last many years. The last four or five years, immigration has been such an issue. I mean, even folks who are were legal citizens from this country had been picked up by ICE and have been deported. So when there was a huge, huge impact, a huge spread of immigration, new immigration laws, and ICE officers popping up in places, it just made the whole atmosphere even more depletive in terms of folks needing to ask for help or seeking help.

Diane:

So secondary prevention, let's talk about screening. Any questions so far? 'Cause I'm seeing everything here. Okay. Families report difficulty with relating with victims after they leave an abuser, and it's due to PTSD. Well, I want you to consider this. I want you to consider this for anyone who may have had any kind of experience like this over any period of time, it depletes your normal brain functions. It's very hard.

Diane:

Even, let's just imagine this, let me do something very abstract here. Think of a hammer... An iron, a hammer, and then an iron nail going into say, maybe an iron wall, you hit it enough times it may not go through, but eventually you start to see a dent in the nail. So it's not always the... What is said consistently, it's not always the beings consistently. It's the fact that it's the constancy, the consistency of attacks, so I consider that a combination of those and then how it affects and how it can possibly affect an individual who starts to feel like second guessing themselves, who is... Starts to may be very nervous about saying anything, they're already impacted on what they can say, when they're not going to say. It's a whole relearning process to engage again, in what may have been normal for that person before the abuse had its impact.

Diane:

It's a relearning process. It's not too dissimilar from what happens to people who go into addiction treatment and they had been using for a long time, that brain has to go back to normal. The psychosocial interventions that you put in place help support its new redevelopment process, where a person can relearn how to live again, how to have breakfast again, how to be, how to maintain a healthy environment, how to maintain a job. The person has to relearn that it's the same thing for the victims.

Diane:

So let me just tell you, all right. So before I go to the screening tool, the case that has always stood out to me more than anything has been the case, and this was decades ago, I think. Yeah, it wasn't decades ago. It was Joel Steinberger- Joel Steinberg. So the way he came to light him, Lisa Steinberg and Hedda Nussbaum. So Lisa Steinberg was little girl who was abused and left and died, and because of his abuse, Joel Steinberg presented very well to the public. He was a very successful attorney. And even though he was at first referred to as the adoptive parents of Lisa Steinberg, he never actually went through the legal process, but they decided to have the little girl and have her at home. But he started, he was abusing her. I mean, I'm talking about atrocious situations, and not giving her a food and not cleaning her and the battery that happened on her. So she ended up dying.

Diane:

Many people in the public. Okay. Well, he was the bad guy really blamed also the wife, well actually Hedda Nussbaum, was his live-in partner. He was, she wasn't legally married to him and her name was Hedda Nussbaum. But before, because the public doesn't know about the impacts of these situations, see Hedda Nussbaum we did not have the capacity to stop her abuse. And that is something hard for a lot of uninformed people to understand. So what was found that she ended up turning state's evidence against him. So she was not indicted in that process, but she went through a lot of hell on that stance. What a lot of folks didn't realize afterwards, after he had gone to jail, he had, he's been released. I think he was released about three years ago. He did his time, but I think what people don't understand... So I followed through on that case, Hedda Nussbaum was required to go into a residential, mental health treatment.

Diane:

She went through two years. Initially, she went through two years of intensive therapy. That means therapy throughout the day, seven days a week. And for two years it took her that long before she was finally able to say, to before she had that glimpse of awareness of clarity that it came to her, she realized she was abused. She had been so bad and so abused for so long herself. She did not have the capacity to actually help that little girl. She could only do as she was told, that's how much she was battered. She was controlled. So just imagine the damage that impacted that whole brain, that little girl lost her life. And then he pretty much took Hedda Nussbaum, his partner's life, because of how he treated them. And it took a while before the public even started to support the idea that he was really guilty after he was found guilty because he presented so well to the public.

Diane:

So you, we never know the intense effect that chronic, that this situation that's so chronically impacts people. It took a long time. She, today she's a motivational speaker for this. She advocates for persons who have been victimized by intimate partner violence, but it took a long time before the public was able to accept her in a different light. And that's because the public is uninformed and many times because the public is uninformed, as someone needs help, many people in the public that might be able to help well now, if you ever seen anybody, I had a client. We used to tell them the time that whenever the same lady that would try to escape her partner, and whenever she would run into him. He would, I mean, she would run away from him and he would chase her around.

Diane:

She would scream out for help and nobody would help her. And so these things happen. Public is uninformed. We have to understand that because of the extreme impact that it can have someone psychologically and mentally and emotionally and certainly spiritually. So what do we do? We have screening tools that we can facilitate. So within our screening protocols, when we are, there are times when we are, we have folks coming into our mental health facilities, into our addiction programs. And so some of the screening tools that we might want to consider using is like they have here, the HITS, the OVAT, the STaT, the HARK. And so they're very specific. These are the ones that show the most sensitivity and specificity. Let me show you this one, the HITS, has four questions. And it's just about understanding if, how the person, how you ask the question is really important.

Diane:

So has, how often does your partner physically hurt you? It's never, rarely, sometimes, fairly often or frequently. And so insult or talk down to threat, excuse me, threaten you with harm scream or curse at you. And so you would note the reactions, the responses rather, here. And so these are the types, the screening, at least to start to give you an idea of what, how, what kind of questions do you want to ask? You can also do the SAFE screening for which includes, do you feel safe in your relationship? Because we always want to make sure safety is always the first thing. I worked a lot with Safe Horizons around training their folks about how they can interact. What are the first things to address with potential clients or women who have been victim or men and women who have been victimized?

Diane:

So stress and safety. Do you feel safe in your relationship? Has your partner ever threatened you or your children, or has your partner ever abused you or your children, if you were hurt would your friends or family know? That starts to give you an indication, how... Are they close to anyone? Are they still in communication? With any type of family or friend resource understanding, would they be able to help that person.

Diane:

Emergency plan is we need the safety plan. We'll go over that now. Do you have a safe place to go to an emergency? Do you need help in locating a shelter? And a lot of women, I will tell you are not open to going to shelters. One of the things that the word shelter brings up very, very negative connotations, a very negative visual. And it's, there's out of the women that I had been working with maybe less than a handful were open to going to the shelter and go through the system to be able to go step by step process, to be able to eventually not just be confidentially safe, but confidentially also be able to access resources that eventually would relocate them. And so understand that if you are going to suggest a shelter, know all that you can about it and show that the shelter that you're trying to suggest or eventually refer to that you are familiar with how the program works, what it looks like, and their outcomes, their successful outcomes in their reporting.

Diane:

This way we can make the best matches, the best resource matches for our clients, with the Hispanic, Latinx community. You want to understand, I said, the language issues are they speak? Do they speak Spanish? What are the age issues? What are the components? What's the structure for the organization? And how are women, what is the program? What is the protocol for the daily living in that shelter? And so elements of safety planning. So become familiar with safe places. First, we want to understand safety planning is not just outside, but also inside the house. So sometimes a person, and we've come a long way from the days when we used to think, well, why does a person stay in there? Why does she stay in her relationship when she could just leave? I think the numbers haven't changed much, but up to 20% of homicides among gender violence women, women who have been victims of gender violence, intimate partner violence, it's about 20% that after they have left them, their abusers, they have come, these abuses have come back, found them and killed them.

Diane:

I gave you just a couple of quick tidbits in the beginning of this presentation of some of the examples of some of the cases, because they were more recent. But to tell you the truth, in reality it happens a lot more often than we unfortunately have to document. So thinking about safe places for that individual outside the house, but also inside the house. So think about a safe place inside the house would be like the place where it's safer to be. Then at a certain part of the place, for a certain part of the house that might not be as safe. So if there's a general breakout and in terms of the abuser being irritated and getting hostile, and then violent then it's probably easier to be in maybe in the restroom than it is to be in the kitchen where the knives are readily accessible.

Diane:

So that's what we mean about safe places within confinement, within a house, and so safe places outside of the house. What places can that person go to? Create a code word. If there are a code word where if you have resources, for outside, that you can connect with who are going to help you, you say a word that person or that they know what that means that you're going to leave, or you have your kids and your kids know, okay, this is, that they know that when you say a word, just get ready to go.

Diane:

Keep computer safety in mind. We talked about that earlier. The computer safety is that being mindful of you're going to use the computer. It's more than just turning it on and off. We really have to be mindful of that. Wherever you visit, whatever website you visit, delete the cache, get rid of that, that footprint. If you send an email, when you in the Sent, once you send it delete that, go into your Sent files, delete that, delete drafts, do these extra steps.

Diane:

Lean on a support network. That person that calls you, that you connect with when they first call you on the hotline or whoever, keep that initial connection going. A support network for a woman can be, or somebody who's been victimized, can be, all right, whether it's family or friends or someone in that safe place. Who's that person who can keep or support, who's that person they can talk to? One of the biggest, biggest helps with women are who are victimized by intimate partner violence, particularly within Hispanic, Latinx community, that don't necessarily like to share this intimation is having someone that they can talk to, someone, some kind of feeling of support that they can trust somebody with, that won't go to the abuser and let them know that. That is helpful while they understand what options they have and what they might be willing to do in a particular situation. Prepare an excuse on the staying safe at home, I started to address right from the beginning. And so safety planning when leaving your abuser. And you've mentioned this earlier, it's like making sure that you already have the-

Diane:

The abuser, and you've mentioned this earlier, it's like making sure that you already have the escape bag, ready. Plan a destination, also plan a route that is not to a destination that this person may be familiar with. Don't plan a route that, help your client to plan a route that is not known, it's not commonly used. And that the abuser wouldn't think of using. And prepare the support network. Important safety note. So here's what I do. This link, when you get these slides, you'll get them in PDF form, but this link will be live or just Google it yourself. You will come up and you will see a personalized safety plan form. It'll help you ask the appropriate questions. It will help you go right through the steps. I remember when I did it with one of my clients when I was doing direct services.

Diane:

One of the things we did, we made it very specific to her situation, the area she lived. At that time, I was working with clients from the Bronx area of New York. And it's very challenging with certain parts of the Bronx, but she found places where she was able to identify places where it would not be considered a place that she would normally go to. And that helped her, and to include that in the plan as to where she can go. And so that personalized safety plan helped her kind of stay in a place for a day or so while she was able to get into a shelter that was getting ready for her to go into, which was in a part of the Bronx that she wouldn't normally go also. So before starting, one of the things I want to ask you. So here we are, we're thinking about possibly, so we have a client and we have to start asking questions. There seems to be some behavioral indicators that we want to consider asking questions about.

Diane:

So what do you need to do in order to create or develop an atmosphere of trust and comfortability? And I would do this for any type of screening, but particularly for this one. How do you create an atmosphere that's trauma informed, culturally responsive, affirming, prior to beginning the screening with a patient? What are the important things for you as providers to consider? I'll give you a chance to type it into your chat box. Hi, I like that. How would you like me to address you? What language are you most comfortable speaking? Yeah. Okay, a welcoming space. Really, really important. So this question it's not just the report, the initiation, how you greet someone at first, but it's also your physical environment. The combination of the two is very, very important for someone who is potentially dealing with trauma issues and other issues created behind potentially a situation that you're going to ask about, about chronic or rather intimate partner violence.

Diane:

Ask the client about comfort, confidentiality is really important. Let them know that, with confidentiality, many of us used to explain confidentiality in a very quick way. These days, what I do is encourage folks to explain it very specifically to the client, what confidentiality is. And ask them to respond back to you. And have them explain to you what they understand for clarity's sake. That can certainly help to initiate a comfortable trusting environment. So that's a good one. So private screening, multilanguage, what safety and comfort looks like and feels for the client, non judgmental attitude. Very important that they know they're in a safe space.

Diane:

So if it's an affirming environment, how do we know the environment is, when we tell them they're in a safe space, how do we also show it? Right, how would you adjust the issue of the victim reports immediate danger of children and the household? So that you know, I think most of you folks know that. If there are children in the household and there's danger to them, by law what are we supposed to do? We have to report it. We're mandated reporters, doing this kind of work. Okay, we're mandated reporters, we have to report it.

Diane:

And so if they share that with you, you have to share with them well I said that you are required to do that. Part of the confidentiality that you are, and how the organization works, is that you tell them that. As part of the confidentiality protocols that you have in your organization. We're supposed to tell all our clients that, right from the beginning, whether they have an obvious issue or whether or not we know they have an issue of intimate partner violence by the confidentiality let folks know. Listen we're mandated reporters and in some instances, we would have to report it. And that's when, and you explain the instances, including if there's a situation that we're informed about where children's wellness are at risk. We would have to report it. You let them know that.

Diane:

So thank you for that. And so also, but then let's just say, there's no children in the picture. And you are working with them, whether you're working in mental health, whether you working in HIV prevention, whether you working in addiction, no matter what community based type of organization or what have you. Working with people in recovery and support services, you want to consider the comfortability before you start to ask these questions. The reason being is because you're hoping to get clear, accurate responses of what really is happening in their lives. And in order to do that, they have to feel safe with you. They have to feel comfortable with you. Also, if language is limited, if you don't know what language it is. We're always talking about, I do a lot of work around culturally linguistically appropriate services standards, the class standards.

Diane:

And one of the things we always express is do we actually ask our clients and our patients, what their preferred language is? You know really should. Part of our ethical responsibility is to be clear with our community members. So when we're helping someone, particularly not just for IPV, but in particular, because of IPV. You want to ensure that the language is clear, ask them what language, what's their preferred language and understand what that is. Because the demographics in our communities are changing. And the issues that our communities are dealing with tend to change very rapidly. So you want to understand that because you don't want any confusion or misunderstanding or misinterpretation of what you're going to convey or support your client with. So language is really important. Include that in the beginning, and understand, so what's your preferred language? How do you like to be addressed?

Diane:

How would you prefer to be addressed? One of the really nice ways to kind of do that is how you present yourself. And so when you first meet a client, when you first meet a patient and you want to, when you introduce yourself, you can say, so my name is Diana Padilla, and I'm here to meet with you. I tend to go by, my preferred pronouns tend to be she, hers. So if you'd like, I have a place for us to sit in private. If you don't mind, could you follow me? And then just mirror the very things that you're trying to, that you're going to initially ask her for and, her or him. And so, or they, and so what you want to do is establish that and have a comfortable tone, present yourself as approachable.

Diane:

And that's part of personalism. Especially with Latina or Latinx and Hispanic women, Latinas. Approachability but in a safe manner is very important. If they're there that says a lot about their resolve, because even accessing services is not the easiest thing for most people, especially these days. But if they're going to access services, and then you're going to ask them about potentially, maybe some of those issues that you tend to see that they may look like they're beat up, or they have been. That you can ask them these kinds of very intimate type of questions, you want to be as warm and as trusting as possible. So thank you for all those comments.

Diane:

So here's what happens sometimes is responses to some of the questions on a safety plan that you might come across. Sometimes that safety plan questions you might ask them if like, if you were using the hitch screening tool that we passed, that we referred to a few minutes ago, and it says how often does your partner threaten you. You might get a lot of no responses. So you may want to add something as simple as, and not everybody's going to readily accept, maybe they might want to have a, check you out first and be more comfortable with you. And somebody may initially say no to the questions that you asked about potential partner harm in any kind of way. So you can say, I see that you've checked off no for our questions relating to feeling safe with your partner.

Diane:

Do you have any other questions about this issue? If they still say no, then say, please leave the door open. So this is a suggested response. I just want you to know that if anything like this ever does come up, this is a safe place to talk about it and get help. And then just move on with the subject. And as you continue to work with them, you'll be able to generate the rapport and build the trust over time. And what doesn't come out in the beginning of a relationship or partnership with your client, can come out a little later. So identifying their needs is important, ask about IPV. There are a lot of times that providers may not ask questions, and sometimes they don't ask questions because they're not comfortable. They're not sure what to do if they have some affirmative responses. I'll say, okay, I see an input.

Diane:

I would leave out preferred pronouns, preferred implies there are suggestions, but they are not. Okay. You know, it is a personal preference. The idea is just to mimic what you would like to ask them about and get, and really speak to generating an atmosphere of trust. And so, yes, you can say just the pronouns I tend to use are her/she or hers, or they, whatever it is you use. So thank you for that Anna. It's very much individualized, but the idea is to allow them to see that you are approachable. So thank you for that. Identifying the needs so that it's better to understand your clients choices, feelings, and safety issues. By not exploring this issue with a person who potentially is showing you or has changed their behavior after you've known them, or you're just getting to know them.

Diane:

And maybe they have some visible indicators, like some black and blues, or something that might be showing under a sleeve that's coming through in different places. You know, if not asking about them, you're not going to be able to help them to the extent that they need. And we're also always talking about meeting the clients where they're at. So better understand your client's choices, feelings, and safety issues. Understand what experiences that they are going through that are contributing to their health problems. It certainly is going to impact whatever it is that you're trying to help them with. And so when we think about how we are, most of us have been trained to stabilize the different areas of a person's life. So they can focus on either getting help for mental health, or getting help for substance use disorders or maybe they're in recovery, we're supposed to provide them appropriate supports. So for them to be able to do that, we've been trained to help stabilize the other areas that might be challenging or high stressors for them at the moment.

Diane:

Well, this is part of that. So understanding how those extreme experiences affect their health problems and the other issues that they want to address with you is very key. Help them access services, not just for themselves, but also for their children, inform them of their right to be healthy and safe.

Diane:

What we've been talking a lot about here, part of this has been trauma informed care. And how many folks here have been, not only been trained in trauma informed care, but actually utilize it in work, in your practices? How many folks here? Let me see them in the chat box. Excellent. Excellent. There are times, when you do this, when you start, I'm so glad because the more you practice this, the more you see how relevant it is for every area of your life, whether it's personal, whether it's professional, whether it's, even in social circles, it's very, very important to use a preventive approach, which trauma-informed care is. Trauma-informed care emphasizes physical, psychological, emotional safety for both consumers and yourselves. So it helps survivors rebuild a sense of control and empowerment. And this is, I think this is the only time that I put the word survivors.

Diane:

I used to always wonder about the word at one time, the research has shown, folks who have survived those instances were folks who have gotten out of those instances, but are they really surviving if they're still mentally still going, being affected by these issues? And I think what a lot of the advocacy groups and a lot of organizations like Safe Horizon, national domestic violence entities, and organizations that are focused on this have been able to really move upon it's not just being a survivor, but being a thriver. There are folks who can rebuild themselves after having these experiences and be at a thriving position and actually evolve as healthier human beings with interventions, with our support, with the resources that we provide folks, and in the manners that we interact with them. Trauma informed care is so important for all of that. So in practice, it could affect a person's experiences of their services, and we don't want to re-traumatize anyone.

Diane:

We also want to ensure that they can reach out and trust and be able to, when trust has been betrayed, what they can do to actually reach out that not everyone is going to be, or all sources may not be effective or may not be helpful, but it doesn't mean that everyone is like that. So really still ensure that if one resource doesn't work out, we can help with another resource. Re-traumatization in clinical settings, misinterpretation of trauma responses and coping strategies. Huge, really huge. What are some of the effects of trauma that you have seen with your patients and clients? What kind of things have you seen with your clients community?

Diane:

The memory issues. I remember the memories, I remember one girl we had, and I was working in the treatment field and one girl in the halfway house. She was in her earlier part. She had just gone through there, admitted into the program maybe 30 days. And she was having issues. She had partner violence that she did talk about, but she still felt like there was hope for them. And at one point she had memory issues or at one point she had a dream where she remembered the sexual abuse that he imposed on her. And that kind of changed everything for her, changed her perspective completely. And she realized that there was a lot of damage if she couldn't even remember the extent of that abuse within herself. And so with the help that we gave her and some of the information and education that we gave her on the impact of people who have been victimized on the impact of the intimate partner violence, she was able to follow through on some resources we set up for her.

Diane:

And so it's interesting how, what happens with the memory, the distrust? Yes. So distrust, a person has been controlled and kind of reformatted. And we template it as an individual to not be able to do too much, unless asked, unless told by a particular person, those things translate even now out of the physical situation. Cognitively, psychologically, emotionally, it's certainly going to impact on how they can interact with a given individual. So these things, yeah, mistrust is something that you have to bridge, and it really speaks to how you initiate that rapport and build on that partnership with them. And you can be the biggest, helpful resource for them because the one thing that a person who's very traumatized can appreciate is when they can get to a point where they can at least trust one person who's genuinely willing to help them. Ineffective coping strategies.

Diane:

Yes. Everything has to be relearned. And this is extremely important. And so this is why the psychosocial interventions that you put in place are extremely important. Thank you for that. Self seclusion. You will see a lot of people isolated on their own. They're more, they're a lot happier, more comfortable amongst themselves than amongst other peers. Particularly if they're used to that. Defensiveness, yes. Or even being able to just even hold a conversation and for a lot of folks, I've met a couple of women who were, whose interactions were very limited. They were more likely to stay quiet in most interactions, and maybe more likely to talk when it was a one-on-one type of situation. It's really interesting. It really looks different on every person. Thank you so much.

Diane:

So think about this when screening and assessing, think about, use a trauma lens. Understanding intersections of culture, understanding intersections of different types of abuses. Understanding that everyone has different capacities to begin with. Okay. So understanding what the resources and options and supports are. Use a trauma informed approach to screening and assessment and relationship and environment. There's a really, really good information here. I gave you this link to the national sense of domestic violence, trauma, and mental health. Also, what does it take to do that? Understand trauma? If you could get even a little bit of the clinical information about what happens to the brain. It's really helpful in understanding why trauma informed interactions and strategies are so effective. So that could help us as providers to be even more inclined, to be efficient or very, very competent in using some of these strategies.

Diane:

And so awareness of our own responses also, really take that into account. That is so important. I would tell you that I remember in one of my past career moves, I was in an HIV prevention program and I was delivering services and we would talk, we were delivering services to couples at risk. And so I had the female client and my colleague had the male client. And when she realized that he was an abuser, something I didn't tell her because that wasn't part of the information I had to share with her. I had my own client. She, I remember one day what she did was she found a way they were both on site at the time. She found a way to keep him on site. And she told her to leave. To get her to safety. Never addressed anything with me, never brought anything.

Diane:

She just took it upon herself to do that. But the reason she took it upon herself to do that is because her own transference issues came up. So she got scared. She wasn't as informed about strategies to work with victims, persons who have been victimized by intimate partner violence, as she also had her own issues that were unresolved. And so, but initially the first thing is you don't put a person's safety at risk. That could put her at risk. It didn't but it could have happened that way. I had no choice. I had to report that. It's not something you brush under the rug. This actually helped her because in clinical supervision what she was able to get is the support from the supervisor in terms of being able to get resources for her to resolve her issues.

Diane:

And then we made sure that all staff got trained on the safety issues with persons with intimate partner violence. That was around the time that I was working with that organization to develop strategies and protocols and policies around IPV. And so, but this is what happens. We want to be able to make sure that when we use trauma informed care, that we understand that our own stuff might be triggered here. So if we have unresolved issues or past experience with this, acknowledging them as part of not allowing it to be an influence in your interactions with your clients. My colleague was very grateful that she eventually got the help that she needed. She didn't even know that she had unresolved issues. And that was the most interesting thing. Because she's an amazingly caring person. So support to address issues of your own responses and take a trauma informed organizational culture and ongoing training and supervision to help, not just initiate that, but to actually maintain that.

Diane:

And one of the last things I want to say in tertiary prevention is, have your resources understand what are the medical services that you can provide. The law enforcement agencies that you need to connect with. Listen, what I can tell you is if you look, what you can find is there are a lot of precincts that do have an individual or a specialist in that precinct who actually worked with victims of intimate partner violence. While a lot of people may have very bad experiences trying to access the law enforcement in these situations, there are some precincts that actually have this in place. So understand what those resources are. The legal assistance and terms of advocacy and court support, victim assistance programs, support groups, and any others that you might think of. Understand what they are for you in your organization. Also like with any resource, please understand it should not all be those close to home. Many of these resources for intimate partner, for victims of intimate partner violence, should include an array of resources that are not immediately in the community.

Diane:

Because if you keep them right there, they can be found. And that's if, for a lot of your clients who may want to actually take a chance and do something about leaving the situation. And so the resources, while somebody gets better, does not have to be immediately available in that community. Make sure that your resources are broad enough that they include distance agencies. And so I think I am, yes, these are IPV resources for you, intimate partner resources. And yes, you could see interchangeably domestic violence is there. The organization has never changed their name, but they're very, very well known because of that. The national center on violence, trauma and mental health has a lot of current information, a lot of information. Which is really, really great.

Diane:

Think about that and about accessing them. So when you come across a situation that might be slightly more challenging than what you might be used to, what you're used to thinking, what you're used to working with, look back at these slides that you're going to get and look at these links and go back there. They will have the most current information available. And so a year from now, if I haven't done this again, if I haven't, don't present this a year from now, I won't have updated information, these websites keep their information current. They work a lot off the research. And they have specific skills and strategies and resources to give you as well. So please look into that.