

The Enlace Project: Practice Guidelines for Working with Latin@ Pregnant and Parenting Survivors

AN INTEGRATED APPROACH TO INTIMATE PARTNER VIOLENCE
AND REPRODUCTIVE & SEXUAL COERCION



WASHINGTON STATE ATTORNEY GENERAL
WASHINGTON COALITION OF SEXUAL ASSAULT PROGRAMS
WASHINGTON STATE COALITION AGAINST DOMESTIC VIOLENCE

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WASHINGTON STATE ATTORNEY GENERAL

1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 753-6200
www.atg.wa.gov





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For more general multidisciplinary guidelines related to working with pregnant and parenting survivors, go to www.pregnantsurvivors.org, **Practice Guidelines for working with Pregnant and Parenting Survivors: An Integrated Approach to Intimate partner Violence and Reproductive & Sexual Coercion, 2013.**



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Part 1: Introduction

What is Our Vision?

- ▶ Domestic violence, sexual assault, and stalking are all-too-common experiences for Latin@s who are pregnant or have recently given birth.
- ▶ The goal of these guidelines is to present an integrated, multidisciplinary approach to service delivery by health care professionals and domestic violence and sexual assault advocates in order to meet the needs of Latin@ pregnant and parenting survivors.

Where These Guidelines Came From

These guidelines are based on the **Practice Guidelines for Working with Pregnant and Parenting Survivors: An Integrated Approach to Intimate Partner Violence and Reproductive & Sexual Coercion** (Washington State Attorney General, Washington Coalition of Sexual Assault Programs, & Washington State Coalition Against Domestic Violence, 2013). The organization Futures Without Violence developed a set of guidelines for reproductive health care providers, which served as the foundation for the 2013 Practice Guidelines.

Based on our advocacy programs' experience in working with survivors over the years, the Washington Coalition of Sexual Assault Programs (WCSAP) and the Washington State Coalition Against Domestic Violence (WSCADV) identified the gaps in service provision faced by pregnant and parenting survivors: access to services, trauma-informed services from professionals in various disciplines, and a coordinated system of interventions and referrals. We realized that a clear set of practice guidelines could help to address these issues.

Building on our state's history of collaborative, multidisciplinary approaches, project partners recruited knowledgeable professionals from across the state to serve on a workgroup to develop the original guidelines, which were finalized in 2013. The project also included a needs assessment (Siebold & Fawcett, 2012) and the piloting of the practice guidelines in three demonstration site communities across Washington State. The final product was a toolkit for multidisciplinary professionals, available at www.pregnantsurvivors.org.

Guidelines to Enhance Services for Latin@ Communities

Building on the **Practice Guidelines for Working with Pregnant and Parenting Survivors** (www.pregnantsurvivors.org), the current guidelines seek to incorporate the skills and knowledge of health care professionals and advocates who provide services to members of Latin@ communities. Gaining a clearer understanding of the complexity of the lived experiences of Latin@ communities begins with recognizing how discrimination based on social inequalities compounds every aspect of life. We worked with advocates and health care professionals in rural counties in central and eastern Washington State to identify the ways in which the Practice Guidelines should be modified. This region has a high proportion of Latin@ residents, including migrant workers, farm workers, and indigenous communities. The voices of these health care professionals and bilingual, bicultural advocates are incorporated throughout this document to illuminate the range of experiences faced by Latina@ communities.

These guidelines were funded through Project Enlace, a collaboration among multiple state and local agencies to provide support to pregnant and parenting teens to finish high school. Enlace (pronounced en-LAH-say) means to intertwine or interlace. The term encompasses some of the key concepts and values of this project:

- ▶ Among Spanish-speaking communities, enlace is commonly used to describe the bond that parents (or other caregivers) form with a new baby, or a strong and healthy bond and relationship between intimate partners.
- ▶ In both Spanish and English, enlace can also include the healthy bonds and relationships we encourage in the communities we work with, and the collaboration among all the agencies and individuals involved in this process.
- ▶ Enlace also captures the idea that a variety of different types of service providers need to work together to help pregnant and parenting individuals affected by abuse and assault. Our program weaves together services from public health, education, and advocacy, among other disciplines.

Throughout this document, we have chosen to use the term “Latin@” rather than using “Latino or Latina” or the plural male version (“Latinos”) that is often used inclusively. See page 15 for explanation.

Since Project Enlace seeks to improve access to culturally and linguistically appropriate services for the Latin@ community in our target region, these revised Practice Guidelines are a key component of this work. The goal of culturally and linguistically appropriate services is to “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs” (Office of Minority Health, 2013, para. 2).

We recognize that the Latin@ community is many communities, comprised of people who are immigrants and American-born; who are monolingual in either Spanish or English; who are fluently bilingual; or who come from indigenous communities with their own native tongues. Their families originate from Mexico, Cuba, Guatemala, and a host of other countries, and vary in customs, traditions, values, and beliefs. Because of this diversity, it is critical for service providers to become well acquainted with the people they serve in their own communities.

In Washington State as a whole, Latin@s make up 12% of the population, and this proportion is steadily growing: there was more than a 77% increase in the Latin@ population between 2000 and 2011. Thirty-five percent of Latin@s in Washington are immigrants (PewResearch Hispanic Trends Project, 2013, Appendix Table A2). Undocumented immigrants accounted for 3.4% of the Washington population in 2010, and 5.1% of the labor force (McClellan, 2013).

Because of discrimination and inequality, survivors in Latin@ communities in the United States face major challenges that affect the need for culturally specific health care and advocacy services:

- ▶ **Employment and Economic Insecurity:** Significantly, fewer Latin@s go on to college or earn above the median income for all Americans working full-time. The total national poverty rate for Latin@s is close to 26 percent, compared to about 11% for non-Hispanic whites (PewResearch Hispanic Trends Project, 2013). Employment and economic insecurity is also tied to discrimination in the work environment. Latin@ immigrants, particularly those who are undocumented, are vulnerable to wage theft and denial of rights and benefits, including protection against harassment and violence (Salcido & Adelman, 2004).
- ▶ **Educational Barriers:** Twenty percent of U.S.-born Latin@s and 50% of immigrant Latin@s do not have a high school credential. Contributing factors identified by the American Council on Education (2011) include language barriers, pressing economic needs, legal status, and educational background in country of origin. These educational levels affect job eligibility and therefore family income. In addition, lower educational levels are associated with lower levels of health literacy, which is the ability to obtain and process information about health and health services. More than 75 percent of adults with less than a high school education are at the basic or below-basic level of health literacy, which means it is difficult for them to do tasks such as reading a prescription label, knowing when to take medications, or calculating insurance costs (U.S. Department of Education, 2003).
- ▶ **Barriers to Receiving Health Care:** In Washington State, Latin@ adults are less likely than all other racial or ethnic groups to have a personal health care provider (Governor's Interagency Council on Health Disparities, 2010). Nationally, "the most commonly perceived barriers [to health care access for Latin@s] were the lack of and limitations in health insurance coverage, high costs of health care services, communication issues involving patients and providers, legal status/discrimination, and transportation concerns" (Cristancho, Garces, Peters, & Mueller, 2008, p.633; see also Holmes, 2013; Kauffold, Zuroweste, Garcia, & Drewers, 2004; McGuire & Georges, 2003).
- ▶ **Documentation Status:** Undocumented individuals have reduced access to and utilization of health care services (Vargas Bustamante et al., 2010; Berger, 2009; Salcido & Adelman, 2004). Even when services are not contingent on documentation status, fear of discovery and lack of trust in authority figures play a role in how undocumented people interact with the health care system. "Most women identified undocumentedness as a major and overriding concern that influenced their thoughts about seeking health care, or that complicated their lives with fear" (McGuire & Georges, 2003, p. 190).

- ▶ **Language Access:** A review of the literature found that language barriers had a significant impact on the quality of health care for Latin@s (Timmins, 2002). According to the Pew Research Hispanic Trends Project (2013), 41% of Latin@s nationally speak English “less than very well,” which has profound implications for service delivery. The advocates in our project stated that survivors may not know about services because information is not readily available in their preferred language, and that access to high quality interpretation varies widely among communities and service providers.
- ▶ **Unique Discrimination Against Indigenous People:** Indigenous people from Mexico and throughout Latin America living in the United States face high levels of racism and discrimination. Undocumented status increases vulnerability to mistreatment and suffering in the workplace, lack of access to needed social and health services, and social violence, including hate crimes and gender-based violence (Holmes, 2013; Villalba, 2013).

An example of how housing insecurity affects survivor's lives:

A woman who is undocumented and living in a trailer was burned as a result of an electrical fire from faulty wiring. She was told by her landlord that there would be no help with the medical bills, and she would have to pay to repair the trailer, and was told “Don’t get medical care or I will report you to the police.” And she had to pay \$100 more for additional people living in the trailer.

—*Bilingual/Bicultural Advocate (April 2014)*

- ▶ **Housing Insecurity:** Latin@s experience heightened difficulty in securing appropriate and safe housing not only because of economic barriers, but also because of continuing discrimination. They are offered fewer options to rent or buy, and experienced diminished access to financing (Equal Rights Center & National Council of La Raza, 2013). These limited options may also result in dilapidated housing conditions and poorer access to healthy food sources and other services (Mares & Peña, 2010).
- ▶ **Reduced Social Networks and Isolation:** Immigration, deportation, and the experience of historical trauma can reduce and weaken social networks and create isolation that has an impact on service access (Levers & Hyatt-Burkhart, 2011; Estrada, 2009; Reina, Maldonado, & Lohman, 2013).
- ▶ **Immigration Climate:** Policies have the potential to intensify the burden of distress and to have profound effects on families and children (Levers & Hyatt-Burkhart, 2011).
- ▶ **Transportation:** Transportation can be an issue because of affordability, safety, and availability, particularly in rural areas (Cristancho, Garces, Peters, & Mueller, 2008; Community to Community Development, 2012). In addition, individuals in abusive relationships may be blocked from accessing transportation to services.

These challenges are often daunting burdens for those who are pregnant or caring for an infant and who also face violence from an intimate partner, sexual coercion or assault, or stalking. Service providers who wish to meet the needs of these survivors can benefit from specific knowledge of Latin@ communities' strengths, resources, and needs. For more information on health equity and social justice issues, see the World Health Organization's (2008) publication, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*.

Hispanic, Latino/Latina, or Latin@?

According to the National Resource Center for Healthy Marriage and Families (2013, p. 2), the term “Hispanic” is “commonly used to refer to Spanish-speaking immigrants, but often rejected by Latin American immigrants because “they view it as a government-imposed label.” The report continues, “Many individuals prefer to identify themselves in terms of their ethnic identity—e.g. Mexican American, Puerto Rican, or Cuban—rather than by the terms Latino or Hispanic. It is important to ask clients how they self-identify and if they have a preference.” We have used the terms “Hispanic” or “non-Hispanic” only when referring to research literature that identifies populations by those words.

Throughout this document, we have chosen to use the term “Latin@” rather than the longer “Latino or Latina” or the plural male version (“Latinos”) that is often used inclusively. We made this choice to indicate gender equality or neutrality, except in instances where we use the term “Latina” because we are citing studies where the researchers speak in terms of “women.” We recognize that men, transgender people, and those individuals who do not identify as a particular gender are also affected by the spectrum of abuse we describe.

How to Use These Guidelines

Professionals working with pregnant and newly parenting Latin@s (both teens and adults) can benefit from practical information for addressing the issues of intimate partner violence and reproductive and sexual coercion. This first section of these guidelines gives the reader an overview and some context for how the guidelines were developed. The next three chapters—**Trauma-Informed Services for Pregnant and Parenting Survivors, Reproductive Health Effects, and Guidelines for Working With Teens**—are relevant to all disciplines, and serve as the foundation for the discipline-specific guidelines that follow. Part 5 provides specific guidelines for health care professionals and others who work with pregnant and parenting individuals, such as doulas and childbirth educators. Part 6 offers guidelines for community-based and Tribal domestic violence and sexual assault advocates. While readers may wish to focus on the chapter for their professional group, reading both of the discipline-specific chapters will help give the “big picture” and facilitate collaboration with other fields.

We list the Practice Guidelines themselves, which are actions to enhance services for Latin@ survivors who are pregnant and newly parenting, at the beginning of each relevant chapter. The material that follows includes the rationale for the Guidelines, supporting information, and sample “scripts” or scenarios that bring the Guidelines to life. Not every Practice Guideline will fit every situation; professionals and programs should select the Guidelines that apply to the survivors they serve as well as the structure and values of their organizations. Because much of the content from the original Practice Guidelines applies to survivors broadly, we have chosen to repeat those sections with minimal adaptation to the Guidelines themselves.

Abuse Dynamics and Implications for the Latin@ Community

The abuse faced by pregnant and parenting survivors is complex and challenging. This abuse is generally embedded in a pattern of power and control exerted by an abusive partner, rather than manifesting as isolated incidents or victimization by strangers. This pattern of abuse affects the survivor's decision-making. Abusers are experts in using tactics that take advantage of survivors' vulnerabilities and lack of resources, which may be exacerbated for Latin@s because of the structural factors described previously. Survivors face an intricate mosaic of risks that makes every decision difficult. A well-meaning professional who does not understand this pattern may believe, for example, that the act of simply leaving a partner will ensure the safety of survivors and their babies. The survivor, however, may have a more realistic view of the risks: heightened risk of violence, sexual assault, and even death at the time of separation (DeKeseredy, 2014); financial difficulties; abandonment by friends and family; loss of housing; and the challenges of single parenthood.

Within the Latin@ community, specific factors that may or may not be culturally based may also come into play, heightening risks and reducing access to services. According to Ahrens, Rios-Mandel, Isas, and del Carmen Lopez (2010, p. 284), "Latinas are even less likely to disclose experiences of sexual assault and intimate partner violence, particularly to formal community services." These authors identified a number of factors, from the literature and from their own study, that contribute to this lower disclosure rate:

- ▶ Traditional gender roles and beliefs about marriage
- ▶ Attitudes toward sexual assault and intimate partner violence
- ▶ Cultural norms against sharing personal information with strangers
- ▶ Cultural norms against sharing family secrets
- ▶ The tendency to place the family's well-being above one's own
- ▶ Ideas brought from the country of origin, particularly worry about the family's reputation
- ▶ Fear of violence
- ▶ Respect for authority
- ▶ Taboos against talking about sex and abuse
- ▶ Negative experiences with the legal system in their country of origin

For immigrants, fears and cultural barriers are often heightened and access to resources may be even more limited (Raj & Silverman, 2002; National Judicial Education Program, 2008).

- ▶ Describing behavior as abusive may be more difficult for immigrants because of the stigma attached to being in an abusive relationship.
- ▶ Survivors may fear that seeking help will jeopardize their own or their abuser's immigration status.
- ▶ They may have had dangerous or difficult interactions with authorities or other experiences of abuse in their home countries or on the immigration journey.
- ▶ Abusers may file preemptive complaints against their partners to protect themselves against the threat of deportation.

Advocates who participated in the adaptation of these guidelines identified additional issues relevant to Latin@ survivors.

- ▶ Immigrant survivors may be blocked in obtaining certain legal remedies because their victimization happened outside of the United States.
- ▶ Immigrant survivors may not know that certain services exist, partly because they were unaware of these services in their home countries or the services were not available in their home countries.
- ▶ Survivors' identification and understanding of what constitutes abuse and sexual violence may vary; for example, the idea that spousal rape is a crime may not be familiar.
- ▶ Some survivors have a heightened fear of retaliation because their abusers are involved in gangs, drug cartels, or other organized crime.
- ▶ Survivors who are forced to migrate because they are fleeing violence experience massive life disruption, having had little chance to prepare.

". . . awareness of culturally based perspectives

and interactions between service providers and survivors are key to building a supportive and relevant relationship that can help to promote safety, healing, and justice."

—(*Winters & Morgan, 2014, p. 235*).

Abusers leverage this lack of resources to maintain control; the antidote is to develop a richer variety of community services and supports, to offer more choices to survivors, and to ensure that pregnant and parenting survivors are not turned off by the very professionals who can offer help. This requires a safety net of services in every community, trauma-informed services from all service providers, and compassionate survivor-centered approaches to outreach and intervention.

Even when survivors are no longer in contact with their abusers, their reactions to the trauma of abuse may affect their ability to receive appropriate services and to navigate the experiences of childbirth and early parenting. While survivors can be remarkably resilient, trauma-informed professionals can support survivors' efforts to have healthy pregnancies, positive childbirth experiences, and rewarding relationships with their babies.

For an extensive discussion of cultural considerations

(including immigrant concerns) in intimate partner violence, see the section on Cultural Considerations in the free online course on Intimate Partner Sexual Abuse by the National Judicial Education Program (2008). You can register for the course at <http://njep-ipsacourse.org/reg.php>.

Where are the Survivors?

In order to improve survivors' ability to obtain trauma-informed services and to learn about the availability of advocacy services, we must be able to reach them where they are. We realized that the vast majority of individuals who are pregnant or have recently given birth are involved with the reproductive health care system. They see obstetricians, gynecologists, nurse-midwives, and other clinicians who care for them during pregnancy, childbirth, and early parenting. They seek family planning services for a variety of reasons.

Because survivors may have contact with only one group of service professionals, we believe that it is critical to create a "safety net" of informed professionals in all disciplines. "Reproductive health care providers may be missing opportunities in counseling young women about reproductive health decision-making and contraceptive choice" (Minnis, Mavedzenge, Luecke, & Dehlendorf, 2014, p. 4). No matter where a pregnant or parenting survivor initially seeks help, each service provider should be prepared to offer information and referrals that will link necessary resources and make it easier for the survivor to navigate service systems.

Addressing the Gaps

The Washington State domestic violence and sexual assault coalitions actively work to identify and address gaps in systems and services that affect survivors. Community-level service providers need a shared awareness of problems, informed by the voices of survivors, and they need to work together toward solutions. We must address abuse during pregnancy and early parenting, yet the very nature of that abuse makes it difficult for survivors to access services. Abusers use isolation and monitoring of activities as forms of coercive control over their partners (Stark, 2009). Survivors often do not define what is happening to them as abuse or assault, particularly when it occurs during ongoing relationships. As we have seen, the tactics of abusers and the perceptions of survivors may be exacerbated by factors unique to the Latin@ community.

The barriers Latin@ survivors face are often complex and overwhelming, and are embedded in the institutions and services they are trying to access. Therefore, we wanted to build on the information gathered in the demonstration site projects and the 2012 Needs Assessment (Siebold & Fawcett, 2012) to tailor the Practice Guidelines in a culturally-specific way. Working with new partners in areas with a high Latin@ population, we were able to harvest the wisdom that bilingual/bicultural victim advocates and health care professionals have gathered from working with survivors in order to create suggested practices in these fields.

Professionals who work with pregnant and parenting adults and teens have an essential role in discussing healthy, consensual, and safe relationships with all clients. Our goal of coordinated and integrated care, as represented by these Practice Guidelines, will enhance Latin@ survivors' sense of safety and autonomy and increase the efficacy of interventions by service providers.

Incorporating Advances in Service Delivery

Dr. Elizabeth Miller, in combination with Futures Without Violence and other partners, conducted groundbreaking research (Miller et al., 2011) that highlights the need in the reproductive health setting to address specifically all forms of abuse and coercion, with some eye-opening results. Women who received a brief intervention centered on health care providers giving them a safety card were significantly more likely to leave a partner because the relationship was unhealthy or they felt unsafe, compared to women who did not receive the intervention.

The research-informed approach of Futures Without Violence offers a model and some newly defined concepts, such as reproductive coercion, which consists of “birth control sabotage” as well as pregnancy pressure and coercion. (These concepts are defined below.) These controlling behaviors affect reproductive health and are linked to rapid repeat pregnancies, which may further entrap a survivor in a relationship with an abusive partner. Because these forms of abuse often overlap with domestic violence and sexual assault, and because health care providers can address them with practical, collaborative interventions, we knew we needed to include this work in our project. These nationally recognized innovative tools and materials are endorsed by the American College of Obstetricians and Gynecologists (Chamberlain & Levenson, 2012).

Limitations of the Existing Research

Because the Latin@ community is so diverse, and because underserved populations are often underrepresented in the research literature, there are many gaps in the knowledge available at this time. Conducting and presenting research without an appreciation for the interlocking factors related to inequality, economic disparities, and discrimination may draw a picture that is both inaccurate and unjust. Foulkes, Donoso, Fredrick, Frost, & Singh (2005, p. 39) stated, “Although several national organizations and numerous local groups are dedicated to improving Latino health, significant gaps exist in the breadth and depth of information available on Latina sexual and reproductive health.” These researchers find that data analyses often compare Latinas with other groups on only one or two indicators; studies often have so few Latinas that effective comparison is impossible; and the existing information is not well organized and accessible to service providers or policymakers. Furthermore, they found that when disseminating the results of their studies, researchers were sometimes disrespectful of the community-based organizations that assisted them. Despite these limitations, we have incorporated existing data into this document in an attempt to capture the prevalence and magnitude of these issues and complex dynamics.

A Paradigm Shift: “Don’t Ask, Just Tell!”

From our original project, we developed the “Don’t Ask, Just Tell!” approach. In this approach, rather than focus on screening, advocates and health care providers are encouraged to provide simple materials and clear education about healthy relationships, reproductive and sexual coercion, and intimate partner violence to every individual they serve. Domestic violence and sexual assault advocates and health care providers sometimes hesitate to ask direct questions about reproductive and sexual coercion before there is an opportunity to develop rapport with an individual. This approach is a useful response to that dilemma.

The “Don’t Ask, Just Tell!” approach built upon the brilliantly simple Safety Card intervention developed by Futures Without Violence (FWV). They created a series of attractive, easy-to-read fold-out cards that contain essential information about “how your relationship affects your health.” Health care practitioners were trained to use the card to briefly inform patients during regular medical appointments. For health care professionals, the idea was to switch the focus from a traditional screening approach, which seeks to uncover information about the patient, to an educational approach, offering information that may be beneficial to a wide variety of people and opening the door to further communication. This evidence-based intervention had surprisingly powerful results:

A brief intervention was associated with a 70% reduction in the odds of male partner pregnancy coercion among women who recently had experienced intimate partner violence. Study participants who were asked about reproductive coercion and then counseled about harm-reduction strategies — including switching to longer-acting contraceptives and contacting domestic and sexual-assault resources — were also 60% more likely to report ending a relationship because it felt unsafe or unhealthy (Futures Without Violence, 2010, para. 2).

The “Don’t Ask, Just Tell!” approach has several advantages over a traditional screening that seeks to have individuals disclose whether they are experiencing abuse. Domestic violence and sexual assault advocates involved in the project discovered that they could offer critical information about the availability of emergency contraception and pregnancy tests in a timely manner without having to ask sensitive questions requesting disclosure about reproductive and sexual coercion early in the advocacy relationship. Survivors have legitimate concerns about disclosure, ranging from retaliation if the abuser finds out, to a loss of privacy and risk of humiliation in their interactions with professionals. Since many survivors focus on other priorities when seeking services, the Safety Card intervention provides critical information without requiring disclosure from survivors. In addition, in the health care setting, offering this information as part of the routine allows people to use it when they need it; they may not be ready to address abuse, or may need the information for a future relationship.

The “Don’t Ask, Just Tell!” approach also removes gatekeeping barriers. Since the information is offered across the board, not just to individuals who might be perceived as high risk, clients who might never be perceived to be in coercive relationships can safely learn about resources. We know that most people in abusive relationships never make it through the doors of an advocacy agency; they are more likely to turn to friends or family than to formal service providers for help. When patients or clients receive a Safety Card and some useful information during a routine medical appointment, for example, they are then better prepared to help a friend who is experiencing abuse.

Examples of this approach include:

- ▶ Community-based advocacy programs began routinely to incorporate information about reproductive coercion, emergency contraception, and pregnancy tests in their intake or early advocacy sessions with clients, including handing out the FWV Safety Card.
- ▶ Community-based advocacy programs began routinely to incorporate information about reproductive coercion and birth control that is less detectable by an abusive partner into ongoing conversations with survivors, such as during support groups, individual advocacy, and safety planning.
- ▶ Health care providers began to use the Safety Card intervention with patients on a routine basis.
- ▶ Other professionals involved in this project provided Safety Cards, posters, and handouts in their offices to let people know that they could discuss reproductive health or coercion issues and obtain referrals.
- ▶ Law enforcement included the Safety Cards in the packet of information offered to domestic violence victims at the scene of an incident.

"Don't Ask, Just Tell!" Could Serve the Latin@ Community

As described previously, identification and disclosure of abuse may pose a particular challenge for Latin@ survivors, particularly those who face systemic barriers (Ahrens et al., 2010). The “Don’t Ask, Just Tell!” approach, using the Futures Without Violence Safety Cards, fits what we know about help-seeking among Latin@s. According to the Sexual Assault Among Latinas (SALAS) Study (Cuevas & Sabina, 2010, p. 98), “One of the most opportune points of intervention...appears to be medical settings.” This makes sense because people are much more likely to go to a health care provider initially than to an advocacy agency. Thus, incorporating an intervention that does not require the survivor to disclose, yet offers education, support, and access to resources, is an excellent fit for the Latin@ community.

The Safety Cards are designed to be given to service recipients who can also choose to share with their friends or family. This fits the informal help-seeking patterns of Latinas in the SALAS study, who were most likely to talk to family and friends about abuse, if they spoke to anyone about this concern. A variety of Safety Cards, fitting various individuals such as teens or new mothers, are available in both English and Spanish. The emphasis on training health care professionals to learn about and offer culturally-appropriate supported referrals (such as to bilingual/bicultural victim advocates) as part of the Safety Card intervention can also bridge the gap to advocacy services for Latin@ survivors, who are unlikely to seek these services directly (Cuevas & Sabina, 2010).

There are some limitations with the use of the Safety Card intervention. While the cards are available in both English and Spanish, this still excludes indigenous people who speak neither language. Written translations may not be helpful because some of these native tongues have no written form. Programs and professionals may address these challenges through creative communication methods such as radio announcements or the use of promotoras (community peer educators).

Terminology Considerations

Victim, Survivor, Patient, or Client?

Each profession has its own terms to describe the people it serves. In these guidelines, we generally use the terms preferred by the specific discipline we are addressing. For example, we use either “survivor” or “client” in the advocacy guidelines. We chose to say “client” rather than “patient” in the health care guidelines, because it seemed to fit a wider variety of settings, including health education and mental health programs.

Broad Definitions

One of the challenges in the field of family violence research has been a lack of standardized definitions. The National Consensus Guidelines (Family Violence Prevention Fund, 2004) provide a working definition for intimate partner violence (IPV), also known as domestic violence (DV). Developed in collaboration with national experts and approved by the Agency for Health Care Research, the Consensus Guidelines are widely accepted in research and practice. Although adolescent relationship abuse (also known as dating violence) is included in the definition of IPV, experts in the field have noted that while many aspects of adolescent relationship abuse are similar to IPV, there are also distinct characteristics relative to the age of the victim and/or perpetrator and different patterns of abusive behaviors. For this reason, a definition for adolescent relationship abuse is included below.

Intimate Partner Violence

Intimate partner violence is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, with the goal of establishing control by one partner over the other. This term applies to heterosexual and lesbian, gay, bisexual, transgendered, queer/questioning (LGBTQ) relationships.

Adolescent Relationship Abuse

Adolescent relationship abuse refers to a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person within a relationship (including dating), where one or both partners is a minor. This term applies to heterosexual and LGBTQ relationships. Similar to adult IPV, the emphasis on repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (such as a single experience of sexual assault occurring at a party where two people did not know each other). Sexual and physical assaults occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors that aim to maintain power and control in a relationship. For adolescents, such behaviors include monitoring cell phone usage, telling partners what they can wear, controlling whether a partner goes to school that day, as well as manipulating contraceptive use.

Sexual Coercion

Sexual coercion involves a range of behaviors that may include coercing a partner to have unwanted sex, forcing a partner to have sex against their will, and/or interfering with a partner's choice to practice safer sex. Sexual coercion may involve verbal pressure without threats of harm, threatening with physical injury, physically restraining, holding down, inflicting injuries, or giving alcohol or drugs to incapacitate a person or impair their judgment. Examples of sexual coercion, which may occur in heterosexual or LGBTQ relationships, include:

- ▶ Sexual assault/rape
- ▶ Threatening to harm a partner unless he or she agrees to have sex
- ▶ Forced noncondom use or not allowing other contraceptive use
- ▶ Intentionally exposing a partner to an STI (sexually transmitted infection) or HIV (human immunodeficiency virus)
- ▶ Pressure or force to engage in intercourse after giving birth, before being medically cleared, which can contribute to a rapid repeat pregnancy

Working Definitions for Key Terms in these Guidelines

The intersections among IPV, reproductive and sexual coercion, and reproductive health have enhanced our understanding of the dynamics and health effects of abusive adult and teen relationships. This has led to new terminology to describe forms of abuse and controlling behaviors related to reproductive health. For the purposes of these guidelines, we provide working definitions for key terms below.

Reproductive Coercion

Reproductive coercion can be present in LGBTQ and heterosexual relationships.

Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. Examples of reproductive coercion include:

- ▶ Explicit attempts to impregnate a partner against that partner's will
- ▶ Controlling the outcomes of a pregnancy
- ▶ Coercing a partner to engage in unwanted sexual acts
- ▶ Forced noncondom use
- ▶ Threats or acts of violence if a person doesn't agree to have sex
- ▶ Intentionally exposing a partner to a STI/HIV

While these forms of coercion are especially common among people experiencing physical or sexual violence by an intimate partner, they may occur independently of physical or sexual violence in a relationship and expand the continuum of power and control that can occur in an unhealthy relationship. The following definitions are examples of reproductive coercion:

Birth Control Sabotage

Birth control sabotage is active interference with contraceptive methods by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Examples of birth control sabotage include:

- ▶ Hiding, withholding, or destroying a partner's birth control pills
- ▶ Breaking a condom on purpose
- ▶ Not withdrawing when that was the agreed-upon method of prevention
- ▶ Pulling out vaginal rings
- ▶ Cutting out a partner's birth control implant (Nexplanon)

Pregnancy Pressure

Pregnancy pressure involves behaviors intended to pressure a partner to become pregnant when that partner does not wish to be pregnant. These behaviors may be verbal or physical threats or a combination of both. Examples of pregnancy pressure include:

- ▶ I'll leave you if you don't get pregnant.
- ▶ I'll have a baby with someone else if you don't become pregnant.
- ▶ I'll hurt you if you don't agree to become pregnant.

Pregnancy Coercion

Pregnancy coercion involves threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy coercion include:

- ▶ Forcing a partner to carry to term against that partner's wishes through threats or acts of violence
- ▶ Forcing a partner to terminate a pregnancy when the pregnant partner does not want to
- ▶ Injuring a pregnant partner in a way that leads to a miscarriage

Birth control sabotage, pregnancy pressure, and pregnancy coercion can apply to any relationship where one partner is able to get pregnant. For example, an individual in a lesbian relationship may insist that her partner be artificially inseminated to bear a child, using physical or emotional threats to force the issue.

Magnitude of the Problem and Focus

National and Washington State Data

A new research study, the National Intimate Partner and Sexual Violence Survey (Black et al., 2010), studied the prevalence of control of reproductive or sexual health by an intimate partner, and found that:

- ▶ Approximately 8.6% (or an estimated 10.3 million) of women in the United States reported ever having an intimate partner who tried to get them pregnant when they did not want to, or refused to use a condom.
- ▶ 4.8% reported having had an intimate partner who tried to get them pregnant when the woman did not want to become pregnant.
- ▶ 6.7% reported having had an intimate partner who refused to wear a condom.

Unintended pregnancy may be linked to abuse. Researcher Elizabeth Miller (2010) found:

- ▶ Intimate partner violence significantly increased the odds of unintended pregnancy. In a 2010 survey by the National Domestic Violence Hotline (2011) involving more than 3,000 callers, one in four women reported some form of birth control sabotage or pregnancy coercion. The questions asked and the responses are listed below:
 1. Has your partner or ex-partner ever told you not to use any birth control (like the pill, shot, ring, etc.)? 25% said yes.
 2. Has your partner or ex-partner ever tried to force or pressure you to become pregnant? 25% said yes.
 3. Has your partner or ex-partner ever taken off the condom during sex so that you would become pregnant? 16% said yes.
 4. Has your partner or ex-partner ever made you have sex without a condom so that you would become pregnant? 24% said yes.

Research on women in Washington State from 2006-2008 reveals the prevalence of assault and abuse related to pregnancy (Washington State Department of Health, 2010):

- ▶ 10% of women reported any abuse by an intimate partner around the time of pregnancy, including physical (5%), psychological (7%), or sexual (2%) abuse.
- ▶ Nearly 22% of teens (ages 15-19) report experiencing physical, psychological, or sexual abuse by an intimate partner around the time of pregnancy.

IPV and dating violence are pervasive and persistent problems that have major health implications for women and adolescents.

- ▶ Approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner (Brieding, Black, & Ryan, 2009).
- ▶ Almost half (45.9%) of women experiencing physical abuse in a relationship also disclose forced sex by their intimate partner (Campbell & Soeken, 1999).
- ▶ Each year, 400,000 adolescents experience serious physical and/or sexual dating violence (Wolitzky-Taylor et al., 2008).

These estimates do not include other forms of victimizations such as psychological abuse, threatening harm, or reproductive coercion. Researchers find much higher prevalence rates in clinical settings.

- ▶ Among women enrolled in a large health maintenance organization, 44% reported having experienced physical, sexual, and/or psychological IPV in their lifetime (Thompson et al., 2006).
- ▶ Two in five (40%) female adolescent patients seen at urban adolescent clinics had experienced IPV; 21% reported sexual victimization (Miller, 2009).
- ▶ Among women seen at family planning clinics, more than half (53%) reported physical or sexual IPV (Miller et al., 2010).

As previously noted, birth control sabotage, pregnancy pressure, or pregnancy and sexual coercion may occur in heterosexual, LGBTQ, or mixed-orientation relationships.

- ▶ Studies suggest that lesbian and bisexual teens are two to seven times as likely as their heterosexual peers to experience or contribute to unintended pregnancy (Saewyc, Poon, Homma, & Skay, 2008). Saewyc and colleagues suggest that these higher rates may be at least partially due to “stigma management,” and research that correlates higher pregnancy rates for lesbian and bisexual teens with an increased exposure to discrimination and harassment would tend to support that conclusion.
- ▶ In a study of transgender and intersex people, 50% of respondents had been raped or assaulted by a romantic partner, though only 62% of these individuals (31% of the total) identified themselves as survivors of domestic violence when asked (Courvant & Cook-Daniels, 1998).

Latin@-Specific Data

According to the National Intimate Partner and Sexual Violence Survey:

- ▶ Approximately 1 in 7 Latina women in the United States have experienced rape in their lives and more than 1 in 3 have experienced other forms of sexual violence; 1 in 7 have experienced stalking; and more than 1 in 3 have experienced intimate partner violence (Black et al., 2011).

In an article presented to the American Congress of Obstetricians and Gynecologists (Clark, Allen, Goyal, Raker, & Gottlieb, 2014), the researchers studied more than 600 women presenting to a large, urban clinic for obstetrical or gynecological care, 48% of whom were Latina, and found:

- ▶ 34.7% of the Latinas in the study experienced some form of reproductive coercion, compared to 18.9% of the general study population.
- ▶ 39.4% of Latina survivors of reproductive coercion were also victims of intimate partner violence, compared to 33% of the general study population.

According to Finer and Zolna (2011):

- ▶ More than half of Latina women's pregnancies are unintended – 54%, compared to 40% for “non-Hispanic” white women.
- ▶ 38% of Latina women's pregnancies end in abortion (compared to 39% for “non-Hispanic” white women).
- ▶ The unintended birth rate (unintended pregnancies that result in a birth) for Latina women 15 to 44 years is 45 per 1,000 women.

However, Natalie Hernandez (2013) makes the point that the meaning and consequences of unintended pregnancies and births among Latinas may be complicated; this point will be discussed in Part 3.



Part 2: Trauma-Informed Services for Pregnant and Parenting Survivors

“Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.”

—From the National Center for Trauma-Informed Care

What are Trauma-Informed Services?

Service providers from all disciplines, including health care professionals and domestic violence and sexual assault advocates, can offer trauma-informed services to those they serve. We use the word “trauma” to mean the psychological or emotional aftermath of overwhelming events that create profound disturbance in survivors’ lives.

Trauma-informed services approach people from the standpoint of the question “What has happened to you?” rather than “What is wrong with you?” It is important to note that providing trauma-informed services does not mean service providers must determine exactly what has happened to an individual. Rather, organizations and providers should examine the way in which they conduct business and make modifications based upon an understanding of how a trauma survivor might perceive what is happening.

Trauma Throughout the Lifespan

These guidelines focus on serving survivors of sexual assault, domestic violence, and stalking that has occurred while they are pregnant or parenting an infant. Thus, these individuals have experienced relatively recent trauma. It is important to consider, however, that many survivors have been victimized multiple times in their lives; many of them may have experienced physical or sexual abuse in childhood as well as during their adult years. They may also have experienced more than one form of adult abuse. For example, an estimated 68% of women who have been physically assaulted by an intimate partner have been sexually assaulted as well (McFarlane & Malecha, 2005). Experiencing multiple terrifying events can lead to “complex trauma,” which may affect many aspects of survivors’ ability to function.

Trauma Can Create Barriers

Trauma survivors sometimes (although certainly not always) present as “difficult” clients. Perhaps it is hard to understand why a particular survivor seems hostile or reluctant to trust you. Sometimes people who have experienced trauma use drugs or alcohol to cope and to numb the intolerable feelings that accompany the memory of what happened; sometimes they “tune out” in other ways. For example, a sexual assault survivor may have a difficult time describing bodily sensations to a health care provider, because she has learned to disconnect from the feelings of her body. Advocates, who are experts in dealing with trauma survivors, can offer partner agencies information and training about the effects of trauma and can join in brainstorming how to create a more trauma-sensitive environment.

Culturally-Specific Trauma-Informed Care

Recognizing that individuals in the Latin@ community may have been exposed to high levels and multiple types of trauma is critical to providing trauma-informed care to adolescent and adult survivors. The various factors described in Part 1 of this document raise the possibility of exposure to traumatic events. The National Child Traumatic Stress Network (NCTSN, 2007, p. 2), in a large-scale national study of children who have experienced trauma, found that:

Latinos/Hispanics in this study experienced a lower incidence of sexual abuse and neglect but a higher incidence of domestic violence, impaired caregiver, and community violence when compared to Caucasian children. Almost three times as many Latinos/Hispanics as Caucasians experienced community violence.

Community violence is defined as “...exposure, as a witness or through actual experience, to acts of interpersonal violence perpetrated by individuals who are not intimately related to the victim” (Child Study Center, n.d.). NCTSN also makes note of the high number of Latinos who live in poverty, another source of significant chronic stress.

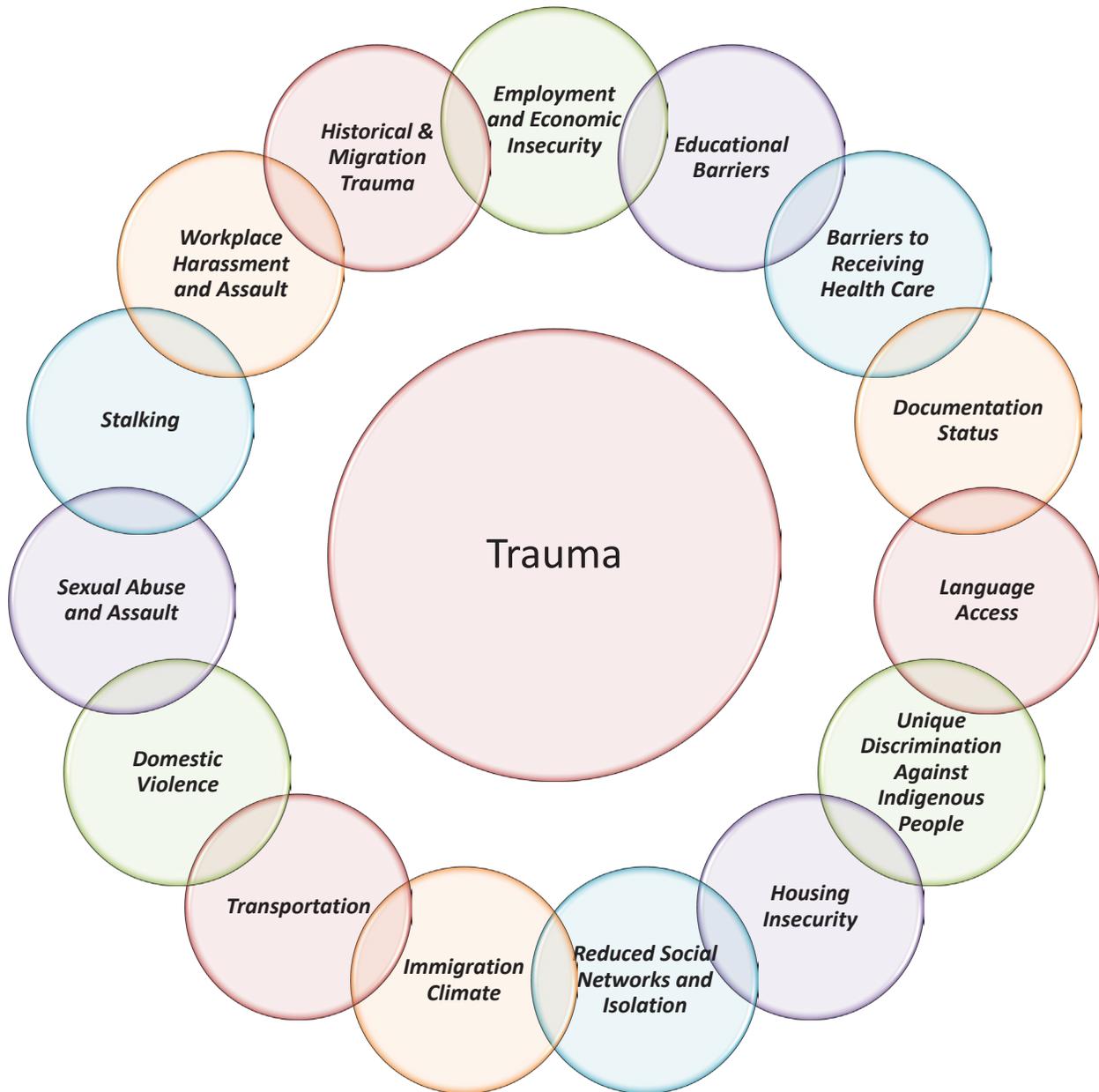
We see a lot of gang issues.

Killings, drugs. It’s stressful for parents because they are worried about their kids joining gangs or being harmed by gangs. They say, “Don’t come to my house – we had a drive-by shooting.”

—*Bilingual/Bicultural Advocate (April 2014)*

It is important not to make assumptions about the cultural beliefs and practices of Latin@ individuals, given the diversity of national origins and varying levels of identification with mainstream American culture. It helps to know something about various principles that are common in certain Latin@ cultures, but it is still critical to have a dialogue with each survivor about their own experiences, beliefs, and values.

Compounding Factors that Contribute to Trauma



It is also critical to learn about the current reality and the history of the communities you serve, in order to understand the context of survivors' lives, in keeping with trauma-informed principles. Latin@s who migrated from countries afflicted by war or unrest may have experienced additional trauma in their country of origin or during migration. The concept of

Clients don't talk about what happens during migration.

—*Bilingual/Bicultural Advocate* (April 2014)

historical trauma, which is the cumulative and psychological wounding across generations emanating from massive group trauma, is valuable in understanding how entire communities may show signs of posttraumatic stress (Brave Heart, 1998, 2003). It is likely that these experiences affect survivors' health and interactions with service providers (Estrada, 2009; Levers & Hyatt-Burkhart, 2011).

“Almost every immigrant family endures crisis simply because they have migrated from one country and culture to another, and many have gone through various types of traumas and distress in their countries of origin”

(*Teverovsky, M., 2013, p. 1*).

An Array of Needs

Trauma-informed care is even more critical when individuals seeking services have experienced a variety of types of abuse, sometimes called “polyvictimization.” This is common in the lives of abuse survivors, and particularly for Latin@ survivors and immigrants. While they experience many of the same types of violence as other survivors, some aspects may be different, for example, trauma related to inequality, lack of documentation, or the migration journey.

For example, a recent study of Latina teens who had experienced dating violence (Sabina, Cuevas, & Bell, 2013) found that “Most dating violence victims (70.8%) experienced another form of victimization (conventional crime, child maltreatment, peer/sibling victimization, sexual victimization, and stalking victimization) in the past year” (p. 2). Professionals who are aware of the diverse abuse survivors may have experienced can become more sensitive to their practical and emotional needs and can be better prepared to offer an appropriate range of resources.

Knowing about the range of trauma helps advocates and health care professionals to avoid inadvertently contributing to survivors' trauma burden. Without this knowledge, it is possible to misinterpret attitudes and behaviors that may spring from other traumatic events, past or present.

Interpreter Services, Language, and Trauma-Informed Care

While service provision by a bilingual, bicultural professional is ideal, it is not always possible. It is important to consider interpreter services from a survivor-centered perspective. We have described how particularly sensitive discussions of partner violence or sexual assault (or any sexual experience) may be for Latin@ survivors, and the presence of an interpreter may make it more difficult to establish rapport and address concerns about confidentiality.

In addition, some of the terms used in victim advocacy and the provision of medical care may not be in everyday usage and may be subject to misinterpretation. Unless interpreters have specific training in issues related to interpersonal violence, they may display negative emotional reactions to survivors' words, thus creating an additional barrier. Finally, it is critical not to use friends or family members as interpreters if at all possible, because of the sensitive nature of the topics to be discussed.

Service providers working with interpreters should have a method for ascertaining whether the survivor is comfortable with the particular interpreter and should learn basic skills for working with interpreters, as suggested by bilingual/bicultural advocates in our 2014 workgroup:

- ▶ Speak slowly and clearly.
- ▶ Speak directly to the survivor rather than the interpreter.
- ▶ Keep your words and sentence construction simple to make interpretation easier.
- ▶ Provide a resource sheet for interpreters on intimate partner violence and sexual assault, with translations for commonly used terms.
- ▶ Request that the interpreter convey all information (such as comments in English by another person in the room).

Language access is not as simple as procuring a Spanish interpreter or translating written materials into Spanish. There are 273 languages spoken in Central America, and 448 languages in South America. “The Mixtec, Nahuas, Otomí, Purhépechas, and Triques are among the largest indigenous groups migrating to the United States” (Pick, Wolfram, & López, 2011, p. 2). While some individuals speak Spanish along with another language, others do not. Even among Spanish-speaking cultures, there are different dialects and idioms from country to country or region to region. Some of the indigenous languages are transmitted through oral and cultural traditions and not via written form. For indigenous languages that do have a written form, literacy levels are low (Thompson & Phillips, 2013). In some ethnic groups, particularly in rural areas, nearly all members of the specific community may know each other, and this can cause complications with regard to interpreter confidentiality.

The quality of interpretation is a major concern. Advocates mentioned court interpretation as one of the most problematic areas because of the technical nature of the material being translated and the potential for miscommunication.

Advocates offered some practical suggestions for assessing the quality of interpretation:

- ▶ Ask a staff member who also speaks the language to be present at some point and to give feedback about the adequacy of the interpretation.
- ▶ Pay attention to disparities in the quantity of information given in each language. For example, if the client relates a long story and the interpreter says only a few words in translation, it is likely that the content is not accurately represented.
- ▶ Observe the client's expressions and reactions to see if they are consistent with the content being interpreted.
- ▶ If possible, follow up with survivors to ask for feedback about specific interpreters.
- ▶ Give the survivor the proposed interpreter's name in advance.
- ▶ Be aware that even when interpreters are certified, they are not required to have any specific training in domestic and sexual violence issues.

Advocates and health care professionals in agencies that were able to choose specific interpreters kept a list of those who provided the highest quality services, and requested those interpreters. While it is not best practice to use survivors' family members or friends as interpreters, in the real world, this sometimes happens, particularly for less sensitive topics. For example, advocates and health care providers stated that if a professional interpreter were not available for a particular time, they would keep the conversation more general and away from specific trauma topics while a family member interpreted. This can become complex when, for example, a Spanish interpreter is available, but a family member must translate from Spanish to Mixteco (an indigenous language) for the survivor, and there is no Mixteco interpreter within that community. In fact, advocates state that finding interpreters for indigenous languages was very difficult and sometimes impossible.

The Washington State Department of Social and Health Services (DSHS) "...currently certifies social service interpreters, medical interpreters, translators, and DSHS active/potential bilingual employees, mental health licensed agency personnel in Spanish, Russian, Vietnamese, Mandarin Chinese, Cantonese Chinese, Korean, Cambodian, and Laotian. The Department also qualifies social service interpreters and medical interpreters in all other languages (screening test)" (Washington State DSHS, n.d.). There is also a specialized program for qualifying court interpreters in Washington State. There are national organizations that certify medical interpreters, and also organizations that certify translators of written materials. See the Resource section at the end of this chapter for more information.

Teens and Trauma

Trauma-informed care is of particular importance in working with teen survivors (see Part 4). Teens often reveal the aftermath of trauma through difficult behaviors – such as substance abuse, anger, or lack of cooperation with services. Latin@ teens may have an added burden of stress and trauma. In fact, the rate of attempted suicide by Latina girls is 13.5%, significantly higher than for black or non-Hispanic white teen girls (Centers for Disease Control and Prevention, 2012).

Traumatic experiences can have a particularly devastating effect on youth, whose important developmental tasks may be interrupted by the need to cope with difficult situations. Trauma affects an individual's world-view and perceptions, and teens may have learned not to trust adults in general or service providers in particular. Professionals must approach teens who have been victimized with compassion and unstinting honesty. Professionals should describe limits to confidentiality in a straightforward and accessible manner at the beginning of any interaction with a teen.

Creating Trauma-Informed Services

The good news is that trauma-informed services are good for every client, not just those who have been traumatized.

Trauma-informed services “incorporate knowledge about trauma – prevalence, impact, and recovery – in all aspects of service delivery, minimize re-victimization, and facilitate recovery and empowerment” (Fallot, Wisconsin Trauma Summit, 2007, as cited in Hudson, n.d.).

The good news is that trauma-informed services are good for every client, not just those who have been traumatized. When you impart knowledge about trauma, even if the client has not experienced that particular event, you assist members of the community to look out for one another. For example, a teen who has not experienced reproductive coercion most likely has a friend who is dealing with that issue. Treating people with respect and enhancing their sense of effectiveness in handling painful issues in their lives is a worthwhile approach no matter whom you are helping.

The “Don’t Ask, Just Tell!” approach that emerged from this project is directly in line with trauma-informed services. By initiating conversations about potentially sensitive topics such as reproductive coercion without requiring a disclosure by the client, professionals acknowledge that survivors have the right to obtain practical assistance (such as learning about birth control that is less likely to be detected by an abuser) without having to decide immediately whether they should tell their stories. Furthermore, talking about abuse can be difficult and disturbing, and a survivor may not wish to put herself through that ordeal just to get the assistance or resources she needs. For example, a health care provider might say, “Women who have had difficult or abusive experiences in the past may prefer us to do things a little differently when they are giving birth. Regardless of the reason, if you think any of the procedures we will talk about may be hard for you to handle, you can let me know and we will try to work out something that will make you feel more comfortable. Okay?”

Do I Really Have to Deal with All This?

You may think that considering trauma is outside the scope of your work. The people you encounter on a daily basis do not have the luxury of deciding not to consider trauma – for many individuals, traumatic experiences shape their perceptions and current experiences. Trauma’s legacy comes in the form of “triggers” – seemingly harmless events that evoke the overwhelming and frightening emotions a survivor felt during the traumatic event. These triggers can evoke such powerful effects that survivors have difficulty coping with apparently minor challenges. Trauma affects people throughout their lifespan, and has an impact on their health and behavior. When we are thinking about pregnant and parenting survivors, the trauma they have lived through may affect their birth experiences (Simkin & Klaus, 2004) and their children.

Principles of Trauma-Informed Care

These principles are taken directly from the Trauma-Informed Organizational Toolkit, a public domain document developed by the National Center on Family Homelessness. They use the term “consumer”; if you feel more comfortable with “client,” “patient,” or some other term, feel free to substitute that term. The Toolkit contains a very useful organizational self-assessment.

UNDERSTANDING TRAUMA AND ITS IMPACT: Understanding traumatic stress and how it impacts people and recognizing that many behaviors and responses that may seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences.

PROMOTING SAFETY: Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.

ENSURING CULTURAL COMPETENCE: Understanding how cultural context influences one’s perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

SUPPORTING CONSUMER CONTROL, CHOICE AND AUTONOMY: Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

SHARING POWER AND GOVERNANCE: Promoting democracy and equalization of the power differentials across the program; sharing power and decision-making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures.

INTEGRATING CARE: Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.

HEALING HAPPENS IN RELATIONSHIPS: Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma.

RECOVERY IS POSSIBLE: Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

What do you need to do to implement trauma-informed services? The specifics will depend on your profession and your role, of course. However, there are some basic principles to remember:

- ▶ A respectful, collaborative approach is more effective than a more traditional provider-client relationship.
- ▶ Remember that the survivor is the expert on her own life and feelings.
- ▶ Do not expect instant trust, but do everything in your power to be trustworthy.
- ▶ Normalize and validate feelings that come from the trauma experience.
- ▶ Ask! Ask the survivor what will help her to feel more comfortable and how you can best work with her.
- ▶ Realize that behaviors that may seem difficult or obstructive have probably served the survivor well in the past. It is hard to give up a behavior that you believe has kept you safe.
- ▶ Maintaining appropriate boundaries is always important, but even more so with survivors, as it contributes to a sense of safety.
- ▶ Learn about the culture, current reality, and history of the communities you serve, but refrain from making generalizations and assumptions. Every client has their own experiences and values.
- ▶ Focus on strengths as well as needs.

Remember that you are important. A guiding principle for trauma-informed services is that “healing happens in relationships.” You cannot fix everything or remove the pain of the past, but every positive encounter helps a survivor to develop skills and maintain hope.

Help Yourself to Help Others

Assisting people who have experienced trauma is difficult and demanding work. Service providers may avoid dealing with issues of victimization because they feel unprepared to handle the practical and emotional consequences of learning about the victimization of an individual. The practical aspect is simple, but not easy. Educate yourself about the issue and available resources, so you do not have to scramble to provide appropriate help. Work to ensure that your program or agency has clear policies and procedures, and know what your next steps should be when a survivor discloses coercion or abuse.

The emotional aspects of providing trauma-informed services are a bit more complicated. It can be draining and disturbing to hear about the painful experiences of others. It is important for service providers to have colleagues or supervisors with whom they can debrief about difficult situations, while always maintaining appropriate client confidentiality. It is also crucial to incorporate self-care and coping strategies into your routine. **Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others** (van Dernoot Lipsky & Burk, 2009) offers practical suggestions for self-care for all professionals who work with survivors.

Maintaining a Strengths-Based Approach

To preserve the dignity, autonomy, and resilience of survivors, a strengths-based approach is encouraged. The focus in this approach is on the skills and fortitude that survivors develop in the face of adversity, and supporting survivors to apply their positive coping mechanisms to ongoing problem-solving. There are many cultural strengths in Latin@ communities that can be highlighted and encouraged to assist survivors in their journey.

Some strengths include:

- ▶ Close-knit families and communities allow for the creation and sustainability of social networks that help to empower Latin@s (Del Castillo, 2007).
- ▶ Latin@ survivors reclaim their lives and sense of power by establishing support groups and socializing their daughters and sons to value nonviolent ways of being and to form healthy relationships (Gonzalez-Lopez, 2007).
- ▶ Latin@s find ways to empower themselves in the workplace, in the family, and within intimate relationships (Segura, 2007).

While these guidelines do not present an in-depth analysis of the strengths within Latin@ communities, this is a critical area of study. We hope that future work with Latin@ communities will focus on this important topic.

Resources

Trauma-Informed Services

- ▶ **Trauma-Informed Organizational Toolkit**
Substance Abuse and Mental Health Services Administration
Available at <http://www.familyhomelessness.org/media/90.pdf>.
- ▶ **Culture and Trauma Brief: Preliminary Adaptations for Working with Traumatized Latino/Hispanic Children and their Families**
National Child Traumatic Stress Network
Available at http://www.nctsn.org/nctsn_assets/pdfs/culture_and_trauma_brief_v2n3_LatinoHispanicChildren.pdf.
- ▶ **National Center for Trauma-Informed Care**
Available at www.samhsa.gov/nctic.
- ▶ **Creating Trauma-Informed Services: A Guide for Sexual Assault Programs and Their System Partners**
Washington Coalition of Sexual Assault Programs
Available at <http://www.wcsap.org/creating-trauma-informed-services-guide-sexual-assault-programs-and-their-system-partners>
- ▶ **Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others**
Book by Laura van Dernoot Lipsky and Connie Burk
- ▶ **When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women**
Book by Penny Simkin and Polly Klaus

Interpretation

- ▶ **Language Testing and Certification Program**
Washington State Department of Social and Health Services
<https://www.dshs.wa.gov/fsa/language-testing-and-certification-program>
- ▶ **How to Become a Certified Interpreter or Translator**
[general information about interpreter certification]
The Language Exchange Inc.
<http://languageexchangeinc.com/how-to-become-a-certified-interpreter-or-translator/>
- ▶ **Washington State Court Interpreter Program**
http://www.courts.wa.gov/programs_orgs/pos_interpret/
- ▶ **American Translators Association**
<http://www.atanet.org>



Part 3: Reproductive Health Effects

General Reproductive Health Effects of Abuse

There is a substantial body of research describing the dynamics and effects of IPV on the health of women and adolescents. Abusive and controlling behaviors range from sexual assault and forced sex, to more hidden forms of victimization that interfere with a partner's choices about sexual activities, contraception, safer sex practices, and pregnancy. In a systematic review of the impact of IPV on sexual health, IPV was consistently associated with sexual risk-taking, inconsistent condom use, partner nonmonogamy, unplanned pregnancies, induced abortions, sexually transmitted infections, and sexual dysfunction (Coker, 2007).

While the research on Latin@ sexual and reproductive health is far too sparse (Foulkes et al., 2005), it is clear that intimate partner and sexual violence have a serious negative impact on the lives of women and teens of reproductive age.

- ▶ In a study at a large obstetrics and gynecology clinic in New England in which Latinas were the largest group represented (42% of the 641 study participants), 16% of total participants and 37% of Latina participants experienced reproductive coercion. A third of all participants and 39.4% of Latina participants experienced both reproductive coercion and co-occurring IPV (Clark et al., 2013). It is notable that the study excluded monolingual Spanish speakers and those who did not read and write in English, and thus may have underestimated the rates of reproductive coercion and IPV.
- ▶ “A recent study of mostly low-income pregnant Latina women in two Los Angeles clinics found 20.5% had experienced IPV within the prior 12 months and 23.2% had experienced it in their lifetimes” (Hart & Klein, 2013, p. 30). The same study (Valentine, Rodriguez, Zhang, & Lapeyrouse, 2011) found that IPV was the most significant predictor of postpartum depression. It was an even more potent predictor than depression during pregnancy, previously thought to have the strongest relationship to postpartum depression.

IPV can be a barrier to survivors accessing reproductive health care.

- ▶ In one study, adolescent girls who experienced IPV were nearly 2½ times more likely to have forgone health care in the past 12 months compared to nonabused girls (Miller et al., 2010).

Sexual victimization increases the likelihood of adolescent risk behaviors and other health concerns.

- ▶ Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide (Behnken, Le, Temple, & Berenson, 2010).

“It got so bad, I tried to kill myself I tried jumping off the bridge, and stuff like that; cause I just couldn't deal with it anymore. I couldn't deal with it. I stopped talking to all my friends. I had a ton of friends from [my hometown], and I wasn't allowed to talk to any of them.”

—Miller, Personal Communication September 30, 2010

Contraceptive Use and Birth Control Sabotage

Women who have experienced IPV are more likely to report a lack of birth control use because their partners were unwilling to use birth control or wanted to get them pregnant (Gee, Mitra, Wan, Chavkin, & Long, 2009). Abused women are also more likely not to use birth control because they cannot afford it and are more likely to have used emergency contraception compared to nonabused women. As with other forms of controlling behavior in abusive relationships, partners interfere with survivors' birth control use.

“Like the first couple of times the condom seems to break every time.

You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid” (Miller et al., 2007).

—17 yr. old female who started Depo-Provera without partner's knowledge

Recent research conducted by the Harvard School of Public Health, University of California at Davis School of Medicine, and Futures Without Violence indicates that a significant portion of women and adolescent girls seeking reproductive health care services have experienced some form of IPV and/or reproductive and sexual coercion. In family planning clinics, 15% of female clients with a history of physical and/or sexual IPV reported birth control sabotage (Miller et al., 2010). In this study, of the 29% of participants who were described as “Hispanic,”

- ▶ 50% had experienced partner violence
- ▶ 16.8% experienced pregnancy coercion
- ▶ 11.5% experienced birth control sabotage
- ▶ 34% experienced unintended pregnancy

The following studies document birth control sabotage:

- ▶ Among teen mothers on public assistance who had experienced recent IPV, 66% disclosed birth control sabotage by a dating partner (Raphael, 2005).
- ▶ The odds of experiencing interference with attempts to avoid pregnancy were 2.4 times higher among women disclosing a history of physical violence by their husbands compared to nonabused women (Clark et al., 2008).
- ▶ Among women with abusive partners, 32% reported that they were verbally threatened when they tried to negotiate condom use, 21% disclosed physical abuse, and 14% said their partners threatened abandonment (Wingood & DiClemente, 1997).

Emergency contraception is another need that is often overlooked for survivors of intimate partner violence and sexual and reproductive coercion. While emergency contraception is routinely offered to victims of sexual assault who present at hospital emergency departments, survivors whose intimate partners interfere with their birth control or pressure or force them to have sex rarely show up in hospitals or the doctor's office. Providing accurate information about emergency contraception helps to dispel misunderstandings about how it works. Some survivors who are worried they may be pregnant may reject the idea of emergency contraception because of the mistaken belief that it is an "abortion pill." A survivor's personal religious beliefs or her partner's opinion may be factors in deciding to use emergency contraception, understanding how it works, or accessing it.

A powerful innovation to counteract the results of reproductive coercion is for advocacy agencies to make pregnancy tests and emergency contraception available on site. Some domestic violence and sexual assault programs in Washington State and elsewhere are using the "Don't Ask, Just Tell!" approach to offer information about the availability of pregnancy tests and emergency contraception in the first contact with program participants. Survivors learn that advocates can answer questions about these concerns and provide options in a timely manner. This approach does not rely on waiting for survivors to disclose their concern about unintended pregnancy or unprotected sex to get information and help. This removes certain barriers for survivors such as having to find transportation to a retail outlet to purchase emergency contraception, find the money to pay for it, and deal with possible privacy concerns or safety issues involving the abuser. In addition, the Washington Coalition of Sexual Assault Programs and the Washington State Coalition Against Domestic Violence (2013) offered a webinar on emergency contraception to educate advocates and dispel myths.

Condom Use

Numerous studies have linked IPV victimization with inconsistent condom use or a partner refusing to use a condom (Wingood, et al., 2001; Teitelman, Ratcliffe, Morales-Aleman, & Sullivan, 2008; Wu, El-Bassel, Witte, Gilbert, & Chang, M., 2003; Collins, Ellickson, Orlando, & Klein, 2005). Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships (Raj, Reed, Miller, Decker, Rothman, & Silverman, 2007), while girls experiencing dating violence are half as likely to use condoms consistently compared to girls who were not abused (Wingood et al., 2001). The connection between IPV and condom use is not limited to physical violence. In a national study of adolescents, girls' current involvement in a verbally abusive relationship was associated with not using a condom during the most recent sexual intercourse (Roberts, Auinger, & Klein, 2005).

“[Women in domestic violence shelters] reported that their abusive partners frequently refused to use condoms, impeded them from accessing health care, and subjected them to birth control sabotage, infidelity, and forced sex. However, women also reported strategies to counteract these actions, particularly against birth control sabotage and attempts to force them to abort or continue a pregnancy.”

(Thiel de Bocanegra, Rostovtseva, Khera, & Godhwani, 2010, p. 601).

In addition, cultural values may have an impact on condom use. Deardorff and colleagues (2013) explored the relationship between sexual values and condom negotiation strategies among young Latin@s, who are less likely to use condoms than other youth. They discovered that both young men and young women who placed a high value on premarital virginity were less likely to engage in direct communication about condom use.

From a public health perspective, promoting condom use without considering the impact of violence and coercion in the relationship is unlikely to reduce unintended pregnancies and STI transmission effectively. In a study of individuals seeking services at an adolescent health clinic (one-third of whom were Latina), more than two-fifths of the sample had experienced intimate partner violence and one in five of the young women in the study had been coerced into having sex without a condom (Silverman et al., 2011).

Unintended Pregnancies

Due to the high rates of birth control sabotage and pregnancy pressure and coercion in abusive relationships, it is not surprising that IPV is a potential risk factor for unintended pregnancies. The following studies have documented this connection:

- ▶ A study in Washington State found that women with unintended pregnancies are twice as likely to experience physical, psychological, or sexual abuse around the time of pregnancy than women with intended pregnancies (Washington State Department of Health, 2010).
- ▶ Among female clients seen at family planning clinics, one in five women who disclosed physical or sexual IPV also reported having experienced pregnancy coercion by their abusive partner (Miller et al., 2010).
- ▶ Adolescent girls currently involved in physically abusive relationships are 3.5 times more likely to become pregnant than girls who are not being abused (Roberts, Auinger, & Klein, 2005).
- ▶ Adolescent mothers who experienced physical partner abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months (Raineri & Weimann, 2007).
- ▶ In Washington State, 5% of women reporting any form of abuse by a partner before or during pregnancy reported being pregnant again two to six months after giving birth, as compared to 1% of women not experiencing abuse (Washington State Department of Health, 2010).
- ▶ In Washington State, nearly 60% of women reporting any form of abuse by a partner around the time of pregnancy reported that the pregnancy was unintended. Approximately 34% of women not reporting abuse experienced an unintended pregnancy (Washington State Department of Health, 2010).
- ▶ A survey conducted by the National Domestic Violence Hotline (2010) found that 25% of women said their partner or ex-partner had tried to force or pressure them to become pregnant.

Unintended Pregnancies and the Latin@ Community

It is important to distinguish between unintended and unwanted pregnancies. Cultural factors may play a role in how an unintended pregnancy is perceived. Latina women are twice as likely as white women to have an unintended pregnancy (Cohen, 2008). In a study of nearly a thousand Latina contraceptive users, Aiken and Potter (2013) found that more than 40% of women who intended to use the pill for another year or more and about one-third of those who said they wanted no more children said that a pregnancy in the next three months would make them very or somewhat happy. Thirty-six women became pregnant during the study, and the majority (24) said they were very happy about the pregnancy. Significantly, those women who believed their male partner would feel very upset about the pregnancy were less likely to be happy about the pregnancy.

“Latina mothers in the United States enjoy surprisingly favorable birth outcomes despite their social disadvantages. This paradox is particularly evident among Mexican-born women. The social and cultural factors that contribute to this are maintained by community networks—informal systems of prenatal care that are composed of family, friends, community members, and lay health workers. This informal system confers protective factors that provide a behavioral context for healthy births. US-born Latinas are losing this protection, although it could be maintained with the support of community-based informal care systems.”

(McGlade, Saha, Dahlstrom, 2004).

A recent study of women at risk for unintended pregnancy (Rocca & Harper, 2012) found that Latina women held more favorable attitudes about pregnancy and childbearing than white women and were more fatalistic about the timing of pregnancy, believing that it would happen when it happened. The Latina women in the study also were more likely than white women to believe that the government encourages minorities to use contraceptives in order to limit the minority population. However, this study found that lower contraceptive knowledge among Latina participants explained the use of less effective methods, rather than disparities in attitudes.

“He really wanted the baby—he wouldn’t let me have—he always said, ‘If I find out you have an abortion,’ you know what I mean, ‘I’m gonna kill you,’ and so I was forced into having my son. I didn’t want to; I was 18. I was real scared; I didn’t wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn’t want to have a baby but I was really scared. I was scared of him.”

—26-year old female (Moore, Frohwirth, & Miller, 2010)

Latina women and teens have reduced access to medical care in general and to reproductive and sexual health care in particular, which has an impact on unintended pregnancy. Foulkes and colleagues (2005) identified a number of barriers that need to be addressed. Because Latin@s are more likely to be low income, they often must rely on public services for reproductive health care. Publicly funded clinics are underfunded and may not offer the full range of contraceptive options, and the pressure to see a large number of patients may lead to impersonal services that are not really tailored to the individual. Immigrants may face additional barriers such as not knowing services are available to them or fearing that obtaining health care may reveal their immigration status. Because Latin@s are underrepresented in the health care professions and qualified interpreters may not be available, patients may have unsatisfactory interactions in health care settings. Foulkes and colleagues also identify a lack of community health education to help Latin@s understand the health care system and “play a more active role in their own care.”

Foulkes and colleagues also mention that despite the documentation of a high pregnancy rate among Latina teens, there is inadequate research about what this truly means in the context of cultural and familial expectations. In fact, teen pregnancy may be seen more positively in some Latin@communities. There is also a lack of information about how traditional gender roles, coercion, and violence affect teen pregnancy rates for Latin@s. There is some evidence that “low power in a sexual relationship with a main partner was associated with an elevated risk of pregnancy” for Latina teens (Rocca, Doherty, Padian, Huggard, & Minnis, 2010). In addition, the Foulkes study mentions the need for exploration of the cultural strengths of Latin@ communities and their impact on health outcomes.

The Role of Pregnancy Coercion in Terminating or Continuing Pregnancies

The relationship between violence and continuing or terminating a pregnancy goes both ways. Individuals who want to continue their pregnancies may not be allowed to, and those who want to terminate a pregnancy may be coerced by their partners to carry the pregnancy to term.

A significant proportion of people seeking abortions have a history of lifetime or current IPV. Reproductive and sexual coercion behaviors such as forced sex, insisting on unprotected sex, and/or refusing to allow a partner to use birth control may result in several unintended pregnancies followed by multiple coerced abortions.

- ▶ An international research review and meta-analysis found that among women terminating pregnancies, 2.5% to 30% experienced physical and/or sexual IPV in the past year (Hall, Chappell, Parnell, Seed, & Bewley, 2014).
- ▶ Women and teens seeking abortions are nearly three times more likely to have been victimized by an intimate partner in the past year compared to women who are continuing their pregnancies (Bourassa & Berube, 2007).
- ▶ Women presenting for a third or subsequent abortion were more than 2.5 times as likely as those seeking a first abortion to report a history of physical abuse by a male partner or a history of sexual abuse/violence by any perpetrator (Fisher et al., 2005).

“My boyfriend was trying to push me to have an abortion . . .

He said, ‘you won’t keep that thing,’ and he threatened to kill me. Then he said he would kill the child...Several times I felt like I wanted to kill myself. I felt like if I had an abortion, I would have to kill myself...When we first met, he said he wanted a family, wanted to marry me, then he changed his mind after I was pregnant.”

(Hathaway, Willis, Zimmer, & Silverman, 2005)

Pregnancy Termination Among Latinas

While the Catholic Church condemns abortion (Catholic News Agency, n.d.), the perception that Latin@s do not have abortions because many of them are Catholic is simply incorrect (National Latina Institute for Reproductive Health, 2004). Thirty-four percent of U.S. abortions are obtained by Latina women and teens (Cohen, 2008). Women who are immigrants from Latin America may have the perception that abortions are unattainable or likely to be unsafe. According to the Guttmacher Institute (2012), abortion is widely restricted and 95% of abortions in Latin America are unsafe; the rate of safe procedures was less than two per 1,000 women.

Sexually Transmitted Infections (STIs) and HIV

Experiencing IPV and/or childhood sexual abuse dramatically increases the risk of STIs and HIV among women and girls (Maman, Campbell, Sweat, & Gielen, 2000; Saewyc et al., 2006; Steel & Herlitz, 2005). According to the American Foundation for AIDS Research (AmFAR), violence is both a significant cause and a significant consequence of HIV infection in women (AmFAR, 2005). A history of IPV is a common denominator in studies of HIV-positive women (El-Bassel, Gilbert, Wu, Go, & Hill, 2005; Gielen, McDonnell, Burke, & O'Campo, 2000; Henny, Kidder, Stall, & Wolitski, 2007). The following studies demonstrate the complex relationship between STIs/HIV and victimization:

- ▶ Women experiencing physical abuse by an intimate partner are three times more likely to have a STI while women disclosing psychological abuse have nearly double the risk for a STI compared to nonabused women (Coker, Smith, Bethea, King, & McKeown, 2000).
- ▶ More than one-half (51.6%) of adolescents girls diagnosed with a STI/HIV have experienced dating violence (Decker, Silverman, & Raj, 2005). Race/ethnicity did not affect the results in this study.
- ▶ Women who are HIV-positive experience more frequent and severe abuse compared to HIV-negative women who are also in abusive relationships (Geilen et al., 2007).
- ▶ Qualitative research with adolescent girls diagnosed with STIs and a history of abuse suggests that the powerlessness they feel leads to a sense of acceptance that STIs are an inevitable part of their lives, stigma, and victimization (Champion, Shain, & Piper, 2004).
- ▶ “Hispanics/Latinos made up 17% of the population of the United States but in 2011 accounted for 21% of diagnoses of HIV infection” (CDC, 2014, para. 1).
- ▶ The incidence of sexually transmitted infections among Latin@s is two to three times the rate among whites (CDC, 2014).

“The guy I was going out with introduced me to drugs.

He had me out there selling my body to get all the drugs and stuff for us, you know? He got to beating on me because I didn't want to get out there no more in the streets doing it, and that's when he broke my cheekbone and everything. That's when I got infected [with AIDS] by him because he kept forcing me to have sex.”

(Lichtenstein, 2005)

IPV perpetration and victimization are associated with a wide range of sexual risk behaviors. Drug-involved male perpetrators of IPV are more likely to have more than one intimate partner, buy sex, not use condoms, inject drugs, and coerce their partners into having sex (Gilbert, El-Bassell, Wu, & Chang, 2007).

For women, being in an abusive relationship increases the likelihood of:

- ▶ Multiple sex partners (Wu et al., 2003)
- ▶ Inconsistent or nonuse of condoms (Wu et al., 2003; Henney et al., 2007)
- ▶ Unprotected anal sex (El-Bassell et al., 2005)
- ▶ Having a partner with known HIV risk factors (Wu et al., 2003)
- ▶ Exchanging sex for money, drugs, or shelter (Henney et al., 2007)

Pregnancy, Birth, and Beyond: The Impact of Survivorship

Impact of Trauma on Pregnancy and Birth

Sexual assault, intimate partner violence, or stalking may have a profound impact on the experience of pregnancy and childbirth. A recent study found that women hospitalized for injuries from an assault by a partner were at greater risk for giving birth to low-birth weight infants than women hospitalized for injuries from car crashes (Aizer, 2011). Physical and sexual abuse are strongly linked to increased prenatal depression rates (Rich-Edwards et al., 2011) and poor pregnancy outcomes (Sharps, Laughon, & Giagrande, 2007). Disturbingly, “abuse during pregnancy is especially dangerous and is a risk factor for lethal abuse” (Kendall-Tackett, 2007, p. 346). Abusive partners are not likely to provide the kind of practical and emotional support needed during pregnancy and birth; moreover, abusers often isolate their partners from family and friends who might provide needed support.

“A peer-reviewed study by outside researchers suggests that doulas provide valuable assistance to pregnant and parenting adolescents by addressing social-psychological issues and socio-economic disparities. Doulas also help pregnant adolescents navigate more successfully through fragmented social and health service systems that are less supportive of low-income adolescents.”

(Gentry, Nolte, Gonzales, Pearson, & Ivey, 2010, as cited in Center for the Study of Social Policy, n.d.)

Most of the literature on sexual assault and the perinatal period focuses on women with histories of childhood sexual abuse, rather than on those who have been sexually assaulted as adults. However, the posttraumatic effects of sexual assault are likely similar to those of childhood sexual abuse, because a major concern in both situations is the triggering of traumatic reactions during pregnancy and birth. Penny Simkin and Phyllis Klaus (2004) have written a vital, practical guide for professionals working with childbearing women with histories of childhood sexual abuse. Most of their strategies and observations also apply to those who have been sexually assaulted as adults. Many aspects of prenatal care and the birth experience may trigger severe anxiety for survivors. Survivors may avoid necessary medical care because of these fears, or they may be so devastated by their experiences that they have difficulty enjoying and caring for their newborns.

Specially trained nurse-midwives and doulas (non-medical support people who assist during childbirth and the postpartum period) can make a world of difference to survivors during this difficult period. Survivors can learn to identify their concerns, communicate effectively with medical personnel, and employ coping strategies that minimize the impact of trauma. Any professional who encounters survivors during pregnancy, childbirth, or the postpartum period can provide more appropriate, trauma-informed services by considering how these experiences may affect someone who has been victimized. While specific help in the medical setting may be outside an individual's professional role, helping connect survivors to appropriate support people can facilitate a healing experience rather than one that retraumatizes the new parent.

An interesting qualitative study of the impact of doulas on the birth experiences of teen mothers suggests that doulas may play a particularly important role in supporting Latina teens (Gentry, Nolte, Gonzalez, & Ivey, 2010). For example, doulas reduced language barriers by translating at medical appointments when no interpreter was available, and they provided transportation to appointments and even to the hospital for the birth. Several of the Latina teens in the study were grateful for the presence of the doula because their own mothers were living in Mexico. For those teens living with the family of their partner, having a more objective source of information was valued. A number of the young women's partners were absent because of working long hours or seeking employment out of the area, and the doulas helped to mitigate the sense of loneliness and isolation that some of the young mothers felt. Doulas helped undocumented teens to access services related to their documentation status. While these doulas did not specifically address intimate partner violence or sexual coercion, their close relationships with the teen client may have offered protective factors and counteracted some of the risks related to abusive relationships. The authors of the study specifically recommended that doulas take a more direct role with regard to screening for and addressing IPV with teens.

Gender Issues in Breastfeeding and Childbirth

While we refer to "women" and "mothers" in discussing childbirth and breastfeeding, we acknowledge that there are individuals who do not identify as women who are able to give birth and breastfeed their babies (some transgender people and people who do not identify as a particular gender). We do not yet have a body of research on this group of survivors in the childbirth and postpartum periods. We urge advocates and health care providers to be attentive to what these individuals have in common with anyone who goes through birth and the early stages of parenting, and also any specialized needs expressed by these survivors.

Impact of Trauma on Breastfeeding

Latina women are highly likely to breastfeed their babies (Gonzalez, 2012; Torres & Cernada, 2003). Eighty percent of Mexican American women breastfed their babies, compared to 79% of non-Hispanic white women and 65% of non-Hispanic black women, despite the fact that lower-income women in general are less likely to breastfeed (Centers for Disease Control and Prevention, 2008). Even among teens, Latina mothers were more likely to breastfeed.

Women who have experienced sexual assault (either as an adult or as a child) may have difficulty breastfeeding. If the assault or abuse involved manipulation of the breasts, the baby's nursing may serve as a trauma trigger that provokes feelings of fear, anxiety, depression, or disgust. Intimate partner violence may also interfere with breastfeeding. A large-scale study (Silverman, Decker, Reed, & Raj, 2006) found that women who were physically abused during pregnancy or the year prior were 35%-52% less likely to breastfeed their infants, and 41%-71% more likely to cease breastfeeding by four weeks postpartum.

“A woman I was working with had recently had a baby and her partner didn’t want her to nurse. He just wanted to control her body and felt a lot of jealousy about the baby. . . she just was feeling so guilty about not being able to provide for her baby the way she wanted to and the way she thought she should be able to. She said ‘I wish I could just nurse when he’s not around or hide it, but now I’m not producing any milk and the baby is hungry.’ [I talked] about her right to her own body, but also keeping her safe because she didn’t feel like she could say ‘This is my right to be able to feed my baby.’ It wasn’t safe for her to do that . . . A lactation consultant and those kinds of resources, I didn’t feel like [those] were viable options [because it wasn’t safe for her to nurse]. She just needed to process her guilt.”

—Advocate, 2012 Pregnant and Parenting Teens and Women focus group

Women who are in physically abusive relationships, or who have experienced physical abuse at any time in the past, may dislike the closeness required by breastfeeding. New mothers in abusive relationships will likely feel stressed, drained, and unsupported, and these feelings may make it difficult for a woman to be physically and emotionally available for the intense relationship created by breastfeeding. In addition, some survivors (of either sexual or physical violence) are very uncomfortable with physical assistance from a health care provider as they learn to position their babies correctly for nursing. In the very practical sense, an abusive partner may be jealous of the nursing relationship or so demanding of the mother's attention that she will be hard-pressed to find the time to relax and nurse.

If a survivor chooses not to breastfeed or is unable to do so, professionals need to be aware that even subtle criticism or stigma may be devastating to these parents. While positive support for breastfeeding is certainly a good thing in general, survivors who do not nurse their babies may feel that others judge them negatively. This can have an impact on their ability to parent.

Sexual or Reproductive Coercion After Childbirth

Health care providers generally advise patients to abstain from sexual intercourse during the period after giving birth until they have a medical check-up. However, abusive partners may not honor this waiting period, and may pressure their partners to have sex before they are physically or emotionally ready to do so. Because new mothers may not have resumed using birth control, this sexual coercion may also lead to rapid repeat pregnancies. Many studies of rapid repeat pregnancies are notable for their lack of attention to the possibility of coercive relationships and the role of abusive partners. Health care providers need to be aware that premature sexual activity may not have been the choice of the woman involved. Clinicians' sensitivity to this possibility may enable new mothers to communicate about abusive relationships.

Resources

- ▶ **Breastfeeding as a Rape or Sexual Abuse Survivor** by Katy.
This article offers very specific suggestions that will be useful to both survivors and professionals such as pediatricians, lactation specialists, and peer breastfeeding counselors who want to support the breastfeeding survivor.
Available online from Pandora's Project at:
www.pandys.org/articles/breastfeeding.html

- ▶ **Intimate Partner Violence (IPV), Breastfeeding, and Nutritional Supplement Programs** by Linda Chamberlain.
From the Futures Without Violence public health toolkit, Making the Connection.
Available online at :
www.futureswithoutviolence.org/section/our_work/health/_making_connection

Paying for Health Care

Information about Affordable Care Act Coverage

Under the Patient Protection and Affordable Care Act, most insurance plans cover preventive care, including annual well-woman visits, all FDA-approved contraceptive methods, pregnancy and breastfeeding support, and domestic violence screenings, at no cost to the plan's enrollee.

- ▶ For current information about coverage, visit this website: <https://www.healthcare.gov/get-answers>
- ▶ For more information about enrolling for insurance and Medicaid in Washington State, visit this website: www.wahealthplanfinder.org
- ▶ Futures Without Violence offers information for providers, advocates, and survivors in the Health Care Guide to the Affordable Care Act at <http://www.futureswithoutviolence.org/health-care-guide-to-the-affordable-care-act/>

Information for Medicaid Coverage (Title X, Take Charge, and Medicaid)

The Title X and Take Charge programs (funded through Medicaid) are designed to provide access to contraceptive services, supplies, and information to low-income people. Due to the current economic conditions and state budget issues, future family planning coverage is uncertain. For the most up-to-date status of Medicaid coverage for family planning services, please go to Washington State's Medicaid website: hrs.a.dshs.wa.gov.

Medicaid also provides pregnancy services, including coverage for abortion, for low-income pregnant people.

Resources

- ▶ **Department of Social and Health Services (DSHS) Take Charge website:** <http://www.hca.wa.gov/medicaid/familyplan/pages/takecharge.aspx>
- ▶ **Take Charge Provider Directory:** http://www.hca.wa.gov/medicaid/familyplan/pages/tc_provider_directory.aspx
- ▶ **Planned Parenthood of the Great Northwest's webpage about Take Charge:** www.plannedparenthood.org/ppgnw/take-charge-23291.htm
- ▶ **Search Title X family planning clinics on the Health and Human Services site:** www.hhs.gov/opa/
- ▶ **Find Washington State family planning clinics that accept DSHS insurance and offer a sliding scale fee for the uninsured at the WithinReach website:** resources.parenthelp123.org/service/family-planning-clinics



Part 4: Guidelines for Working with Teens

Practice Guidelines for All Professionals Working with Teens

(Select the guidelines appropriate for your professional role.)

- ▶ Teens have a unique lingo, so ask teen clients what they mean if you are not 100% sure.
- ▶ Use gender-neutral terms when talking about teens' dating partners.
- ▶ Learn about the relevant state laws related to age of consent.
- ▶ Ask teens for feedback on whether your agency projects a teen-friendly atmosphere.
- ▶ Provide staff training on how to offer a welcoming experience to teen clients.
- ▶ Identify the school-based programs that serve pregnant or parenting teens in your community (GRADS programs or other local school or community programs).
- ▶ Call or visit the teachers and other key school personnel to provide information about your services for teen survivors.
- ▶ Offer to provide in-service training or to participate in a training exchange with school-based service providers on IPV, sexual and reproductive coercion, and trauma-informed approaches to teens.
- ▶ Know your state laws and agency policies about confidentiality and mandated reporting.
- ▶ Have a standard statement about confidentiality that you say to teens during your intake process.
- ▶ Learn about mandated reports regarding the children of teen parents. Exposure to domestic violence does not constitute child abuse or neglect.
- ▶ Make sure you have the knowledge and resources to assist with safety planning prior to making a mandatory report.

Overview

Pregnant and parenting teens are at high risk for sexual assault, sexual and reproductive coercion, and domestic violence. In Washington State, nearly 22% of teens report experiencing abuse around the time of pregnancy (Washington State Department of Health, 2010), and at least 31% of victims of intimate partner homicide began the relationship prior to age 21 (Fawcett, 2010). Because teens may be less likely than adults to initiate contact with service providers specifically about victimization, it is critical that all professionals working with pregnant teens and teen parents be aware and informed about the violence and coercion these young women may have endured.

Adolescent parents who have been physically or sexually abused are at high risk to have a repeat pregnancy soon after they give birth. One study (Raneri & Wiemann, 2007) found that teen mothers who are abused in the first three months after giving birth are almost twice as likely to have another pregnancy within 24 months. An earlier study showed low-income teens who were physically or sexually abused were three times more likely to become pregnant again within 12 months and four times more likely to have another pregnancy within 18 months (Jacoby, Gorenflo, Blacka, Wunderlich, & Eyler, 1999). Clearly, young parents in abusive relationships need attention to both safety and reproductive health concerns. The guidelines in this section apply to both advocates and health care professionals.

Understanding Teens

Successfully navigating the teenage years is not easy under any circumstances. Latin@ teens who are immigrants or children of immigrants often must negotiate different environments with widely divergent expectations about their sexuality. For example, advocates have shared stories from bilingual and bicultural teens who struggle with balancing the values and expectations of their family with messages in the media and from their peers. These conflicting expectations and messages inform the choices teens make regarding their sexual and relationship decisions. Immigrant parents may face greater barriers than nonimmigrants in assisting teens to obtain health care or to learn about youth services. It is important to recognize that there are also strengths and protective factors in immigrant families, such as lower levels of early sexual activity (McDonald, Manlove, & Ikramullah, 2009) and the possible protection of a close-knit community and family (Smokowski, Chapman, & Bacallao, 2007).

11% of Latin@ youth (under age 18) are immigrants

More than half of Latin@ youth are the children of immigrants

Nearly 9 million Latin@s live in mixed immigration status households

—Fuentes, Bayetti Flores, & Gonzalez-Rojas, 2010

Pregnant and parenting teens have additional challenges, and teen survivors of intimate partner violence, reproductive or sexual coercion, or stalking are faced with highly stressful life circumstances. The rapid developmental changes of adolescence combined with challenges such as multiple victimizations, childhood trauma, or family trauma can create formidable barriers for teens to get the help they may need. In addition, the existence of teen subcultures with their own language, technology, and values can make it even more difficult for adults to connect with and assist these teens.

When working with teens, it is important to balance respect for clients' autonomy with an understanding of developmental issues. Adolescent brains are works in progress. Researchers have found that the parts of the brain that control executive functions – such as reasoning, judgment, and inhibition of inappropriate behavior – develop last, and may continue developing into the early 20s. This can increase the likelihood of certain behaviors. For example, because the part of the brain that processes emotions is still developing in young teens, they may be “more likely than older adolescents and adults to misinterpret another person’s actions as negative, threatening, or hostile, and respond accordingly” (Woolard, 2009). Teens are biologically primed to engage in riskier behavior than adults; they may be more impulsive and in general they have more challenges in making sound decisions that take all relevant factors into account.

Adults who provide services and support can have a profound impact on young people. Most of us can recall one or more adults who made a difference during our teen years.

A recent report on Supporting Brain Development in Traumatized Children and Youth states

“Teens benefit from quality time with their caregivers
and adult mentors who help them:

- ▶ Organize tasks and set priorities
- ▶ Practice making decisions
- ▶ Master new skills
- ▶ Seek healthy adventures and take positive risks
- ▶ Minimize stress
- ▶ Adopt healthy lifestyles and allow time for plenty of sleep”

(Chamberlain, 2009, as cited in Child Welfare Information Gateway, 2011).

“While all teens need adults in their lives who can help them gain new experiences and support them through adolescence, teens who have suffered from trauma caused by abuse or neglect can benefit especially from caregivers who encourage their growing independence while also offering a safety net when they need help.”

(Child Welfare Information Gateway, 2011).

The Nature of Teen Relationships

Because many teens are victimized within the context of intimate relationships, it is helpful to understand the nature and dynamics of those relationships. A longitudinal study of more than 14,000 teens (Ryan, Manlove, & Franzetta, 2003) provides an overview of teen relationships. For teens who had sex within what they considered to be a “romantic relationship,” 24% had their first intercourse within the first month they were together. An additional 37% began a sexual relationship within three months of being together. Eighty percent of these relationships last six months or less, and a quarter of them are one-time “hookups.” Approximately one in four teens reported verbal and/or physical violence during their first sexual experience, with physical violence occurring for 17% of Hispanic teens, 12% of non-Hispanic black teens, and 6% of non-Hispanic white teens.

In the Needs Assessment interviews, we asked advocates about their experiences working with teen clients (ages 13-17 years).

Advocates reported that most teens do not want adults in their lives to know they are having sex. As a result, teens lack information and resources about safe sex and sexual coercion. In general, advocates said that teens receive little information from their parents about sex and are often poorly informed.

While these statistics relate only to first-time sexual relationships, given the fact that more than one-fifth of teens never used contraception in their first sexual relationships, a significant number of pregnancies is likely to have occurred in this group. It is interesting that despite the questions on verbal and physical violence in this study, there is no discussion of sexual or reproductive coercion and none of the study’s recommendations address these issues. Even though there is a large body of research (Solano, McDuffie, & Powell, 2007; Klein, 2005; Hall, Holmqvist, & Sherry, 2004) on teen sexual practices and teen pregnancy, an examination of the role of sexual and reproductive coercion is noticeably absent in many studies.

When working with teen survivors, it is important to be aware of the intensity of teen relationships and the fierce commitment some teens have to their partners. Because adolescents see intimate relationships as a bridge to adulthood, teens may perceive any response by a professional that seems to question the wisdom of their relationship choices as an insult to the teen’s emerging independence. Service providers must be especially vigilant not to seem judgmental; an “I know better what is right for you” attitude will be an instant turn-off for most teens, no matter how well intentioned. Even more than other survivors, teens may not self-identify as victims. Careful use of language that is respectful of your client’s point of view will help build rapport. For example, do not describe your client as having been “abused” unless she uses that term or you have had a conversation with her about abuse and her experiences.

“Her boyfriend was a few years older and he was in prison.

He said he was going to search up and down her body to make sure she’s not using birth control so he can get her pregnant. The interesting thing was the duality of her response. It was ‘I don’t want to have a baby. I’m only 17.’ But the other part was ‘Isn’t that romantic?’ at the same time.”

—Advocate, 2012 *Pregnant and Parenting Teens and Women Needs Assessment*

Teens may have some misconceptions about healthy relationships. For example, they may confuse jealousy and possessiveness with love and connection. Both boys and girls may think that boys (or men) are “entitled” to have sex with an unwilling partner given certain circumstances, such as an ongoing relationship, previous sexual activity, or paying for dinner (or some other monetary exchange) (Pemberton & Wakeling, 2009).

It is also interesting to see the differences in teen girls’ and boys’ perceptions of the desirability of pregnancy. While 48% of never-married Latina young women ages 15 to 19 said they would be “very upset” if they got pregnant now (compared to 58% of all young women in the total study), only 27% of never-married Latino young men ages 15-19 said they would be “very upset” if they got someone pregnant (compared to 46% of young men in the total study) (Martinez, Copen, & Abma, 2011, p. 27). In abusive relationships, young women may not be able to express or act upon their desire to avoid pregnancy when their wishes differ from their partners’ wishes, and this discrepancy is wider between Latino male teens and Latina female teens than between young men and women in general.

Because teen relationships are fluid, may be on-again/off-again, and may vary in length and seriousness, it is important to ask teen clients about the nature of their relationships when relevant, rather than to make assumptions. For example, when a pregnant or parenting teen refers to her boyfriend, don’t assume he is necessarily the father of her child. In addition, a pregnant teen or teen mother may self-identify as lesbian or bisexual rather than heterosexual. In fact, “studies suggest that lesbian and bisexual teens are twice as likely as their heterosexual peers to experience unintended pregnancy” (Healthy Teen Network, 2010). There are many reasons for this, including a heightened risk of sexual victimization for LGBTQ (lesbian, gay, bisexual, transgender, or queer/questioning) individuals, poor access to appropriate information and health care services, and a lack of social and family support.

Teen relationships in today’s world are virtual as well as based in physical reality. In the online world or via text message, teens may connect or break up, be stalked or threatened, and receive messages from partners or peers that heighten sexual pressure. Because of the influence of technology and the media, teen language evolves and changes at a rapid pace, so it is important for professionals to ask teen clients what they mean if there is any doubt.

Pregnant teens and teen parents may be stigmatized and treated as though they are irresponsible or stupid. It can be especially painful for a teen who is pregnant as a result of sexual assault or reproductive coercion to be blamed and labeled, and Latin@ teens may be stigmatized even more because of stereotyping. The National Latina Institute for Reproductive Health provides a valuable analysis of the intersection between racism and the stigmatization of teen pregnancy, including extremely harmful stereotypes of young Latina women as being reckless and irresponsible for becoming pregnant (Fuentes, Bayetti Flores, & Gonzalez-Rojas, 2010, p. 6). Recognizing that teens who become pregnant are not very different from those who don't become pregnant (other than the fact that they are more likely to have been victimized) is vital to working successfully with these young people.

Question

How do you think you would feel if you had a baby at 15?

Answer

Maybe I would feel like I would want to hide.
I don't think I could talk to anybody about it.

—*Latina Teen (Community to Community Development, 2012)*

It is also important to recognize that teens are particularly vulnerable to rapid repeat pregnancies. In Washington State, teens 15-19 are 12 times more likely to report another pregnancy two to six months after giving birth than women ages 20 and older (Washington State Department of Health, 2010). A national study (Waggoner, Lanzi, & Klerman, 2012) found that younger teens, ages 14-16, were more likely to have a rapid repeat pregnancy than older teens – nearly 30% of the younger girls became pregnant, compared to 21% of the older teens. There were no ethnic differences in rapid repeat pregnancy; Latina teens were no more likely to have a second pregnancy than white teens.

- ▶ Teens have a unique lingo, so ask teen clients what they mean if you are not 100% sure.
- ▶ Use gender-neutral terms when talking about teens' dating partners.

For teen-friendly information about adolescent relationships, explore the “Your Relationships” page at <http://washingteehelp.org/your-relationships>. The site, WashingTeenHelp, was developed by WithinReach and contains interactive games and videos created by teens themselves. At this time, they are in English only, although the resource hotline for the site offers help in English and Spanish.

Age Disparities With Partners

Teen parents often have significantly older partners. One in five teenage girls has a sexual partner who is four or more years older (Ryan, Manlove, & Franzetta, 2003). Among girls who first had sex at age 14 or younger, 51% had a male partner who was at least three years older, compared with 30% for teen girls overall (National Campaign to Prevent Teen Pregnancy, 2012). A recent study in the journal *Obstetrics and Gynecology* (Smid, Martins, Whitaker, & Gilliam, 2014) found that more than twice as many girls who get pregnant at age 14 or earlier—as compared to older pregnant teens—have partners who are at least six years older (36% as compared to 17%). Girls under age 15 who become pregnant are three times more likely to be “Hispanic” rather than “non-Hispanic white,” according to this study.

- ▶ Learn about the relevant state laws related to age of consent.

Washington State laws about “age of consent” are complicated. Individuals 16 or older may consent to sexual activity, no matter the age of their partners, unless they are under 18 and the partner is a person with supervisory responsibility, a school employee, or a foster parent (RCW 9A.44.093). For those under 16, the age disparity with the partner determines if sexual contact is legal (RCW 9A.44.073, RCW 9A.44.076, RCW 9A.44.079). An excellent resource for this information is the S.C.A.R. (Sexual Consent Assault and Rape) booklet developed by youth from Partners in Prevention Education. You may order free copies from youthchangeagents.org/Informational_Materials.html. An online resource identifying relevant laws is on the King County Sexual Assault Center website: www.kcsarc.org/pop/laws.

Question

How do you feel when someone pressures you to do something you don't want to do?

Answer

Like, what do you mean exactly? Like if a guy is pressuring me to sleep with him?
All I know is that if the girl is 15 and he's 30, people will call her a slut
but they will pat him on the back... That sucks.

—*Latina Teen (Community to Community Development, 2012)*

Advocates who participated in our project shared that it is not uncommon for Latina teens to be involved in intimate partner relationships with older partners. An immigrant's country of origin may have different laws about the age of consent.

Age disparities with partners are of particular concern because they may create an imbalance of power or limit communication (Ford, Sohn, & Lepkowski, 2002).

Creating a Teen-Friendly Service Environment

Traditional healthcare, legal, and advocacy service venues may seem intimidating or unwelcoming to teens. If the only magazine in the waiting room is *Golf Digest*, teens may feel like interlopers. Conversely, teens entering a facility that serves younger children may be turned off by Disney decals on the walls. If your agency has a teen advisory group, its members can assist you with feedback on how teen-friendly your services appear. If not, you may want to recruit some local teens to provide a consumer's view of your agency. Certain barriers may prevent teens from receiving services:

- ▶ Loss of confidentiality
- ▶ Cost
- ▶ Past poor treatment by adults
- ▶ Difficulty with transportation to appointments
- ▶ School, work, and family schedules that conflict with appointments (Seattle & King County Public Health, 2011)

These barriers may affect pregnant and parenting teens more strongly because of their additional needs and responsibilities. Lack of childcare may be an additional barrier for teen parents, and having an abusive or controlling partner certainly makes it difficult for these young people to access needed services.

Some excellent suggestions for reaching out to and welcoming teens are available at <http://www2.aap.org/pubserv/PSVpreview/pages/teenfriendlypractice.html> (American Academy of Pediatrics, n.d.). While these guidelines target health care providers, other service providers can adapt many of the suggestions. Something as simple as providing teen-oriented magazines or offering snacks may make your agency more attractive to potential teen clients. The most important aspect of teen-friendly care, however, is well-trained staff who communicate clearly, listen well, respect confidentiality, understand a trauma-informed approach, and truly enjoy working with teens.

- ▶ Ask teens for feedback on whether your agency projects a teen-friendly atmosphere.
- ▶ Provide staff training on how to offer a welcoming experience to teen clients.

Using Natural Opportunities for Outreach

Because most teens are still in school, forging strong collaborative relationships with school personnel is an excellent outreach strategy. In Washington State, some communities have GRADS (Graduation, Reality, and Dual-role Skills) programs for pregnant students and those with children. You can locate and learn about these programs at www.k12.wa.us/CareerTechEd/GRADSProgram.aspx.

In other communities, support for pregnant teens may be more difficult to locate. Many high schools may not have a GRADS program, but they may have special classes or another program for pregnant and parenting teens. A good first step for identifying school-based resources is to contact the Guidance Department at your local high schools and middle schools.

When you provide prevention programming, remember that it is also linked to service outreach. Most prevention professionals find that some participants will come up to them after a presentation and ask for help with their own situations. Knowing the full range of resources that may be useful for pregnant or parenting survivors is a very effective way to connect these teens to appropriate services.

On WashingTeenHelp.org, a program of WithinReach, professionals and general users of the website can create a personalized resource list at <https://resources.parenthelp123.org/>. The resources are in English only at this time, but the hotline for the site offers help in both English and Spanish.

Action steps to connect with schools

- ▶ Identify the school-based programs that serve pregnant or parenting teens in your community (GRADS programs or other local school or community programs).
- ▶ Call or visit the teachers and other key school personnel to provide information about your services for teen survivors.
- ▶ Offer to provide in-service training or to participate in a training exchange with school-based service providers on IPV, sexual and reproductive coercion, and trauma-informed approaches to teens.

Confidentiality and Mandated Reporting

According to a study from Children’s Hospital in Los Angeles, “**confidentiality is the most important factor in whether or not a teen victim seeks services**” (Teen Dating Violence Technical Assistance Center, 2008). Teens who are victimized are more likely to tell a peer or a trusted adult such as a favorite teacher, rather than the police or their parents. They often do not want their parents or the authorities to know what is going on, for a variety of reasons. Teens may still be in relationships with their abusers, and fear that they will be separated from their partners or that their partners will suffer because of disclosure. Teens may fear reprisal from the abuser, or they may worry (sometimes with good cause) that their parents will make the situation worse. Young parents may be afraid that their children will be removed from their care if they are living with an abusive partner.

While clear statements about the limits of confidentiality are important precursors to any client contact, they are especially important for teens. Teen clients may have excellent reasons not to trust the adults with whom they have had contact, and if you are not straightforward about what you will and will not have to disclose, you may lose their trust forever. Because safety considerations are complex in abusive relationships, teen clients may know that a report will increase their danger, and they have the right to self-select what they are willing to disclose at any given time.

In the 2012 Pregnant and Parenting Teens and Women Needs Assessment survey of domestic violence and sexual assault advocates, 13% of the 173 total respondents who work with teens identified “I am worried I will have to make a report to CPS or police if a teen discloses this kind of abuse” as a barrier to talking with teen survivors about reproductive coercion (Washington State Coalition Against Domestic Violence & Washington Coalition of Sexual Assault Programs, 2012).

Here are some considerations for managing confidentiality issues with teens:

- ▶ Know your state laws and agency policies about confidentiality and mandated reporting.
 - ▶ See the Resources section at the end of this chapter for more information.
- ▶ Have a standard statement about confidentiality that you make to teens during your intake process.

If you are new to your profession, practice making the statement in a clear and confident manner. Even if a client is in crisis, it is important to inform her up front about the limits to confidentiality. You could say, “I know you have a lot on your mind and you seem very upset, but I want to make sure that I let you know about what is confidential or private here, and what may not be, before you go into any details about what is happening.”

Provide an oral as well as a written confidentiality statement to young clients, ensuring they understand exactly what is confidential and what is not. For example, if you say, “I have to report if someone is hurting you,” a 13-year-old client may not understand that you will be making a report about a sexual relationship with a 20-year-old boyfriend. If you provide written confidentiality and consent paperwork in languages other than English, make sure they are professionally translated and the wording conveys the same meaning as the English language documents.

- ▶ Learn about mandated reports regarding the children of teen parents. Exposure to domestic violence does not constitute child abuse or neglect.

If teen parents are in violent relationships, you may be concerned about whether to report possible harm to their children. According to the Department of Social and Health Services, “a child’s exposure to domestic violence in and of itself, does not constitute child abuse and neglect. Domestic Violence is considered child abuse and neglect when it causes harm or creates a clear and present danger of harm to the child’s health, welfare, or safety” (Washington State Department of Social and Health Services, 2010, p. 5).

What to Do When You Must Make a Report

To prevent mandatory reporting requirements from damaging your relationship with a teen client, it is critical that you offer clear, understandable information about the limits of confidentiality from the outset. Then, if you must report, you can let the client know you are doing what you said you must do. Prior to making a report, spend some time with clients explaining the process and doing safety planning. Ask them what reaction they expect from parents and/or their partner, depending on the situation, and assist them with resources to maintain safety if these responses may create danger. Remember to ask questions about how a mandated report might affect not only teen clients, but also their pregnancies and their children. If they express fear, take it very seriously and work with them to create increased safety.

If your professional role does not routinely include safety planning, ask for survivors’ permission to contact a local domestic violence or sexual assault advocate who can assist with this process. Unless an advocate is immediately involved at the time of the mandated report, you still need to address safety issues with your client before making the report. Your local community-based advocacy agencies can assist by offering training about safety planning. See Part 5: Guidelines for Healthcare Providers in this document for more information about domestic violence and sexual assault advocates and how they do their work.

Offer your teen client the option of taking an active role in making a mandated report. If clients talk to Child Protective Services themselves, they may feel a greater sense of participation and control. At a minimum, ask them to be in the room when you make the report, so that the teen knows exactly what was said and to whom.

- ▶ Make sure you have the knowledge and resources to assist with safety planning prior to making a mandatory report.

Resources

- ▶ **Mandated Reporter Toolkit and Video** (Washington State)
<https://www.dshs.wa.gov/ca/child-safety-and-protection/how-report-child-abuse-or-neglect>
- ▶ **Protecting the Abused and Neglected Child** (booklet)
<https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-163.pdf>
Also in Spanish:
<https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-163SP.pdf>
- ▶ **Sexual Assault and Coercion in Teen Relationships**
An archived webinar by Jennifer Y. Levy-Peck, Washington Coalition of Sexual Assault Programs.
Includes slides, webinar recording, and annotated resource list.
www.wcsap.org/sexual-assault-and-coercion-teen-relationships
- ▶ **Toward Developmentally Appropriate Practice: A Juvenile Court Training Curriculum**
While designed for those in the judicial system, these free training modules offer an excellent, user-friendly description of adolescent development and issues in dealing with teens. See especially Module 1 - Adolescent Development and Module 5 – Communicating with Youth: Interviews and Colloquies.
You can download a detailed overview and request a copy of the curriculum on the website linked below.
<http://www.modelsforchange.net/publications/255>
- ▶ **Your Relationships**
WashingTeen Help
<http://washingteenhelp.org/your-relationships>
- ▶ **What’s Your Relationship Reality?**
Stay Teen
<http://www.stayteen.org/relationships>
- ▶ **Resources for Parents of Teens** (in English and Spanish)
<http://www.extension.umn.edu/family/families-with-teens/resources-spanish/>
- ▶ **Teen Health Topics for Parents and Teens from the American Academy of Pediatrics**
(in English and Spanish)
<https://www.healthychildren.org/english/ages-stages/teen/Pages/default.aspx>



Part 5: Guidelines for Health Care Professionals

Practice Guidelines for Health Care Professionals

- ▶ Have a private place to interview clients alone where conversations cannot be overheard or interrupted.
- ▶ Display culturally and linguistically appropriate educational information (addressing IPV, reproductive coercion, stalking, and sexual assault), including posters, hotline numbers, safety cards, screensavers, and resource cards, in common areas and in private locations such as bathrooms and exam rooms.
- ▶ Develop a written training policy and provide staff training on IPV, sexual assault, and reproductive coercion, including the appropriate steps to inform clients about the limits of confidentiality and reporting requirements.
- ▶ Develop referral lists and create partnerships with local diverse service providers and resources. Establish relationships with local community-based domestic violence and sexual assault advocacy programs so that you can make informed referrals and possibly collaborate on training activities.
- ▶ Integrate core training on relationship and abuse issues (including specific training on IPV, sexual assault and coercion, stalking, and reproductive coercion) at general trainings for all clinic staff who have contact with clients.
- ▶ Advanced skills-based training should be offered on an ongoing basis and should cover how to seamlessly integrate assessment and brief intervention into current practice.
- ▶ Always disclose limits of confidentiality prior to doing any assessment with clients.

- ▶ Professionals and staff should use the Futures Without Violence Safety Card for Reproductive Health to facilitate screening and educate clients about healthy relationships and the impact of IPV and reproductive and sexual coercion on health.
- ▶ Offer visit-specific harm reduction strategies.
- ▶ Offer supported referral.
- ▶ Offer clients the use of a private phone in the clinic or office so they can call community-based services without being monitored by abusive partners.
- ▶ Even if you have mental health resources on site, acquaint yourself with local mental health professionals who offer specialized treatment to abuse survivors; you may contact community-based advocacy programs for information about where to find appropriate therapy services.
- ▶ Document screening, referral, and follow-up plans regarding IPV and sexual or reproductive coercion in each client's chart, along with safety considerations for contacting the client for follow-up.

Introduction

A note on language:

Because this section of the Practice Guidelines is intended for a range of professionals working in health care settings, the Statewide Workgroup decided to use the term “client” rather than “patient.”

This section of the Practice Guidelines is patterned closely on the **Reproductive Health and Partner Violence Guidelines** (Chamberlain & Levenson, 2011). Futures Without Violence gave permission to excerpt relevant portions of their work. We adapted some of their material to apply more specifically to pregnant and newly parenting survivors and to incorporate local resources. Futures Without Violence’s brief, evidence-based assessment and intervention tool, the Safety Card for Reproductive Health (reproduced at the end of this chapter), remains the centerpiece of the health care guidelines, along with strategies developed by Futures Without Violence for harm reduction. The research showing the efficacy of the Safety Card intervention was conducted under the auspices of the University of California at Davis Medical School and included 1200 participants at family planning clinics. This study, based on more than 20 years of research about similar interventions, adds to a growing body of evidence that links reproductive coercion with other forms of abuse as well as with increased risk for unintended pregnancies. The Safety Card offers a method for opening the conversation between health care professionals and their clients about IPV and reproductive and sexual coercion, and allows health care professionals to introduce important information about healthy and unhealthy relationships.

Each health care setting is unique in the way services are delivered. While the guidelines in this chapter should be appropriate in a wide variety of settings, they will be implemented in different ways as they are customized for a particular clinic or office. Within these guidelines, the term “health care setting” includes Federally Qualified Health Centers, Public Health Clinics, local health jurisdictions, and community clinics. Remember that these Practice Guidelines are designed for those working with clients interested in family planning as well as pregnant or newly parenting individuals, so the Guidelines will be most relevant to professionals who have direct contact with these people.

Prepare

Create a Safe Environment for Sharing Information

You can take several important steps to create a safe and supportive environment for asking clients about relationship issues that may affect their health.

- ▶ Have a private place to interview clients alone where conversations cannot be overheard or interrupted.
- ▶ Display culturally and linguistically appropriate educational information for Latina@ communities (addressing IPV, reproductive coercion, stalking, and sexual assault), including posters, hotline numbers, safety cards, screensavers, and resource cards, in common areas and in private locations such as bathrooms and exam rooms.
 - ▶ Consider the range of languages spoken in your community and literacy concerns in choosing appropriate materials. Culturally relevant resources such as fotonovelas (pamphlets with photographs and dialogue bubbles) may be useful.
- ▶ Develop a written training policy and provide staff training on IPV, sexual assault, and reproductive coercion, including the appropriate steps to inform clients about the limits of confidentiality and reporting requirements.
 - ▶ Futures Without Violence (www.futureswithoutviolence.org) has a culturally diverse selection of posters, educational brochures, and safety cards.
- ▶ Develop outreach opportunities such as representation at local events, local partnerships to offer services or develop programs, and referral lists for local resources.
- ▶ Develop referral lists and create partnerships with local diverse service providers and resources.
 - ▶ For example, some health care clinics participate in local health fairs that include a variety of service providers. Clinics also use radio shows to distribute public health messages, create programs that support community health, and offer health services in partnership with local agencies in a variety of locations. There are also local, statewide, and national resources addressing issues of abuse. The Washington State Coalition Against Domestic Violence (<http://wscadv.org/memberprograms.cfm>) and the Washington Coalition of Sexual Assault Programs (<http://www.wcsap.org/find-help>) maintain current listings of local domestic violence and sexual assault programs.

- ▶ Establish relationships with local community-based domestic violence and sexual assault advocacy programs so that you can make informed referrals and possibly collaborate on training activities.
 - ▶ These programs provide an array of services, including crisis intervention, advocacy services, shelter, community education, and professional consultation. This face-to-face connection will help you to access appropriate resources for your clients in a timely fashion.
 - ▶ Seek additional or joint funding opportunities to support either co-location or increased access to advocacy support at your health care site.
 - ▶ Learn which advocacy programs employ bilingual, bicultural staff, and what services and materials they have available in the languages relevant to your clients.

Train

Health care professionals are encouraged to seek training on how healthy and unhealthy relationships affect health status.

- ▶ Integrate training on relationship and abuse issues (including specific training on IPV, sexual assault and coercion, stalking, and reproductive coercion) at general trainings for all clinic staff who have contact with clients.
- ▶ Every staff person needs to have basic knowledge about trauma-informed services and an opportunity to build basic skills for working with clients, within the scope of their role.
- ▶ Advanced skills-based training should be offered on an ongoing basis and should cover how to seamlessly integrate assessment and brief intervention into current practice.
 - ▶ This training will offer staff the opportunity to develop and practice discipline-specific competencies based on best practices and a holistic approach to the client.

Who Should Receive Training?

We recommend that all staff who may have contact with clients participate in training. Nonclinical staff such as front desk or outreach workers are often the first people to observe indicators of abuse and they are critical in establishing a supportive, trauma-informed environment. Training may also be offered to other support staff such as security guards, parking lot attendants, and maintenance and cleaning staff, because they may observe abusive or threatening behaviors.

Training Resources

Health Cares About IPV: Intimate Partner Violence Screening and Counseling Toolkit is a free toolkit developed by Futures Without Violence (2013). It can be used for self-directed training and to provide training to your staff (download at <http://www.healthcaresaboutipv.org>). Under Getting Started, you can access training resources including videos and a wide variety of written information. There are resources customized for particular health settings, such as reproductive health, Indian health, and mental health. The toolkit provides a range of resources for IPV screening and brief counseling, offers information about coverage guidelines under the Affordable Care Act. On the training page, you can find Making the Connection: Intimate Partner Violence and Public Health, a free resource that consists of a PowerPoint presentation, speaker's notes, and an extensive bibliography. It addresses the following reproductive health-related topics:

- ▶ IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
- ▶ IPV and Sexually Transmitted Infections/HIV
- ▶ IPV and Women's Health

Free eLearning Activity: Online education opportunities on violence and reproductive and sexual coercion are also available. Go to www.futureswithoutviolence.org for information on new training opportunities as they become available.

Local domestic violence and sexual assault agencies may be able to provide training. The state coalitions (WSCADV and WCSAP) may also be able to provide advanced or specialized trainings in-person or online.

National medical professional organizations may also offer relevant training:

- ▶ American College of Obstetricians and Gynecologists – www.ACOG.org
- ▶ Migrant Clinicians Network – www.migrantclinician.org

Inform

Confidentiality Issues

While reproductive and sexual coercion described in these guidelines are not included in most legal definitions of IPV, some forms such as forced sex would typically be part of the legal definition of IPV. Issues related to dating violence involving a minor can also raise questions about mandatory child abuse reporting requirements and age of consent laws. In addition, professionals need to be familiar with relevant state privacy laws and federal regulations regarding the confidentiality and protection of health information. Make sure that you have accurate, up-to-date information about mandatory reporting laws for Washington (see also Part 4: Guidelines for Working with Teens).

Mandatory reporting requirements are different in each state and territory. Consider contacting the following organizations for information and resources specific to Washington State:

- ▶ **Child Protective Services** in Washington provides information about reporting requirements for minors experiencing abuse. Mandated reporter training information is available at <https://www.dshs.wa.gov/ca/child-safety-and-protection/how-report-child-abuse-or-neglect>
- ▶ The **Washington Coalition of Sexual Assault Programs** (www.wcsap.org) and the **Washington State Coalition Against Domestic Violence** (www.wscadv.org) can provide information and training on reporting requirements for sexual assault and IPV. Information about local domestic violence and sexual assault agencies in your community is also available from these coalitions.

Always disclose confidentiality limits prior to doing any assessment with clients.

Health care professionals need to state their obligations as mandated reporters clearly. This preserves trust, allows clients to make an informed decision about what information they wish to share, and helps to prevent misunderstanding and miscommunication. The scripts below are examples of how to disclose confidentiality limits with a client before assessing for IPV and reproductive and sexual coercion.

Sample Script to Inform Client about Limits of Confidentiality

Adult Client

"I'm really glad you came in today. Before we get started, I want you to know that everything here is confidential, meaning I won't talk to anyone else about what is happening unless you tell me that you are planning on committing suicide or are planning on hurting someone else. I am also required to report any child abuse or abuse of a vulnerable adult."

Teen Client

"I'm really glad you came in today. Before we get started, I want you to know that we respect your privacy. What we talk about here today is confidential. However, there may be some situations that I am required by law to report. If I learn that you are being hurt by someone or being forced to do something sexually that you don't want to do, are planning on committing suicide, or are planning on hurting someone else, I will have to make a report. Also, if you tell me that you are having sex with someone who is much older than you, that is something I have to report as well."

For information about age of consent laws in Washington State, see resources in Part 4: Guidelines for Working with Teens.

If possible, bring the client to the exam room by herself initially to discuss these issues. This is less awkward than asking an accompanying person to leave the exam room. In the waiting room, you can say, "We'd like you to come back by yourself first, and I'll come to get [parent or partner] in a few minutes." If the accompanying individual (or even the patient) balks, you can say, "This is the regular way we do things, so we can get the patient settled in the exam room. I'll be back to get you very shortly."

You may also find it helpful to display signs in your waiting room that state, "All patients will initially be seen alone. If you would like a support person to join you later in your appointment, please let the clinic staff know." These signs should be in multiple languages to reach a broader audience.

Working with Interpreters in the Health Care Setting

Please see Part 2: Trauma-Informed Services for detailed information about language and interpretation issues, as well as practical tips for working with interpreters and assessing the quality of interpretation. Another useful resource is **Models for the Provision of Language Access in Health Care Settings** (Downing & Roat, 2002).

Medical interpretation is a specialty skill, and not every interpreter is qualified and able to interpret medical information. In addition, interpretation of sensitive issues such as discussion of intimate partner violence, sexual assault, and sexual and reproductive coercion requires additional vocabulary and understanding. Bilingual/bicultural health care providers are extremely valuable in working with survivors. When interpreters must be used, health care professionals should allow sufficient time for clear communication and clarifying questions. Pictures and diagrams may be useful as well.

Health care agencies and professionals should search for appropriate patient information materials in a variety of languages or have materials translated by a qualified translator, and not ask an interpreter to translate written medical information “on the fly.”

Ask and Educate

Asking Questions about IPV and Reproductive and Sexual Coercion

Professionals in the Needs Assessment Interviews

Professionals in the Needs Assessment interviews told us that you should expect to hear “no” when you ask if clients have experienced abuse. Unless and until you have the time and opportunity to build a relationship, disclosure of any kind of abuse is rare. Just providing information, like giving out the Safety Card, is an intervention that may be effective even without a disclosure. It may be useful to your client, a family member, or a friend.

“Mostly we don’t find this all out in one visit. That’s why [physicians] have a hard time cracking this. They don’t have enough time. We get to know them a bit, they trust us. The first time, nothing’s wrong. The second time, out it comes.”

—*Maternity Support Services Nurse*

While assessment questions for IPV may be embedded in self-administered questionnaires or computerized interviews, asking questions about IPV and reproductive and sexual coercion also needs to be part of the face-to-face interaction between the professional and the client. The client’s responses to these questions help to inform the professional about the best way to proceed relative to potential complications, compliance considerations, other health risks, safety concerns, and developing an appropriate treatment plan. This informed approach will ultimately save time and enhance the quality of care and health outcomes.

“She was a little bit older, this was her third baby, she had really bad diabetes; it would have probably been better to not have another child. And she felt like she was done. So I would ask every time I saw her – and her husband came to all her appointments, which is a problem – ‘so, are you thinking about having your tubes tied after this baby?’ And she’s like, ‘Well...’ and looks at the husband and he says ‘Oh, no, we’re not going to do that.’”

—*Health Care Professional, 2012 Pregnant and Parenting Teens and Women Needs Assessment*

Educate: The Futures Without Violence Safety Cards for Reproductive Health

“It'll save you time in the long run if you ask the right questions.”

—Sandy Owen, RN, Member of 2011-2013 Statewide Pregnant and Parenting Teens and Women Workgroup

Futures Without Violence has developed Safety Cards on reproductive coercion and violence for adults and teens that are available at no cost (other than nominal shipping costs). You can download or order hard copies of these resources, available in English and Spanish, through their website (https://secure3.convio.net/fvvpf/site/Ecommerce/567623699?FOLDER=1133&store_id=1241). Sample Safety Cards are provided at the end of this chapter. A teen Safety Card, entitled *Hanging Out or Hooking Up?* is also available. Futures Without Violence also has Safety Cards for new parents during well-baby visits. You may also have business cards from your local domestic violence/sexual assault agency or other local resources readily available. The FWV Safety Cards are designed for clients to answer questions about their relationships, including whether their partners are interfering with their ability to make choices about their reproductive health. Approximately the size of a business card, the Safety Cards include:

- ▶ Questions about elements of healthy and unhealthy relationships
- ▶ Questions asking whether they experience IPV, birth control sabotage, pregnancy pressure, forced sex, and other controlling behaviors
- ▶ Suggestions for what to do if they are experiencing IPV and/or reproductive coercion
- ▶ Hotline numbers

Professionals should use the Futures Without Violence Safety Card for Reproductive Health to facilitate screening and educate clients about healthy relationships and the impact of IPV and reproductive and sexual coercion on health.

- ▶ This can be done by adjusting the wording (for example, changing “Does my partner...” to “Does your partner...”).

Sample Script for Giving Out the Safety Card (in English & Spanish)

"We've started giving this card to all our clients. This card is like a magazine quiz. It talks about healthy and safe relationships, and ways in which your relationship may affect your reproductive health. If anything on this card is a concern for you, I can tell you about some really great [people, clinics] in our area, and even help you to make an appointment if you would like to do that. These cards are also great to share with friends."

“Tenemos una tarjeta que hemos empezado a repartir a todos nuestros clientes. Es similar al cuestionario que usted tomaría en una revista. Tiene información valiosa no solo para usted pero también para amigos y familiares. Esta tarjeta habla de como sería un relación saludable. Habla también de su salud y los efectos que pueden tener en su relación. Si en algún momento usted o alguien que conoce tiene preguntas o preocupaciones sobre esta tarjeta, sientase libre de preguntar para que pueda conectarle con la persona correcta y/o agencias en nuestra área para contestarle esas preguntas y/o preocupaciones. Si usted gusta, también puedo ayudarle a usted o a alguien que usted conoce a hacer una cita.”

When healthcare professionals share information about birth control methods, they should not assume that patients are free to make their own decisions about their reproductive health. It is useful to identify birth control methods that are less likely to be interfered with or felt by a partner, and which methods do not disrupt menstruation.

“Based on a growing body of research, it is clear that a striking number of sexually active women experience reproductive coercion by their male partners and are thus potentially compromised in their ability to use contraception and plan pregnancies” (p. e7).

“Health care providers should routinely assess reproductive-age women for reproductive coercion and intimate partner violence and tailor their family planning discussions and recommendations accordingly” (p. e1).

(Clark, Allen, Goyal, Raker, & Gottlieb, 2013)

Promoting Prevention

Part of client education is talking about healthy relationships. The reproductive health care professional can also play an important role in preventing abuse by offering education and anticipatory guidance about what a healthy relationship looks like, particularly for adolescents. Examples given by health care professionals in the 2011-2013 Statewide Pregnant and Parenting Teens and Women Workgroup are shown below.

Professional Tip

Prior to asking questions about IPV and reproductive and sexual coercion, it is helpful to find out whether a client has sex with men, women, or both, so you can focus assessment on questions that are relevant to the client. Don't assume a pregnant client has only male partners.

For example, for a woman who is engaging only in same-sex relationships, questions would focus on IPV and sexual coercion; it would not be necessary to ask questions about birth control sabotage.

Universal Messages about Healthy Relationships

“One of the things that I talk to all my patients about is how you deserve to be treated by the people you go out with. You have the right to:

- ▶ Be treated with kindness
- ▶ Be with your friends when you want to be
- ▶ Wear what you want to wear
- ▶ Feel safe and have your boundaries respected
- ▶ Go only as far as you want to go with touching, kissing, or doing anything sexual
- ▶ Speak up about any controlling behavior including textual harassment such as receiving too many texts, phone calls, or embarrassing posts about you on Facebook or other sites.”

You may wish to reinforce these concepts by displaying a poster or giving out bookmarks developed by WCSAP that read, “In ANY relationship, you have the right to say ‘yes’ or ‘no’ to every sexual act any time for any reason, without fear. It’s your choice. It’s the law. If making that choice scares you, help is available.” You can customize these posters and bookmarks with local advocacy program information. They are available for free download in six languages at www.wcsap.org/ipsv-resources-publications.

Intervene

Ask about other control and abuse in her relationship.

Sample Script

“What you’re telling me about your relationship makes me wonder if there are other things that make you uncomfortable. Has there ever been a situation where your partner has hurt you or pushed you to have sex when you didn’t want to?”

Basic guidelines for responding to IPV in a health care setting are outlined in the National Consensus Guidelines on Responding to Domestic Violence Victimization in Health Care Settings (Family Violence Prevention Fund, 2004). Intervention strategies discussed in the Consensus Guidelines include:

- ▶ How to do a health and safety assessment
- ▶ Suggested language to provide validation to a client who discloses abuse
- ▶ How to respond to safety issues
- ▶ How to document a client’s disclosure and abuse history
- ▶ Strategies for offering information and making referrals to local agencies
- ▶ Confidentiality procedures and mandated reporting

Offer Visit-Specific Harm Reduction Strategies

- ▶ Offer visit-specific harm reduction strategies.

“We had a situation where we distracted the husband with meaningless paperwork so she could get Depo [an injectable form of birth control]. We were asked to go administer it quickly, don’t say a word. She had an appointment...for something unrelated and she told the professional that’s what she wanted.”

—Health Care Professional, 2012 Pregnant and Parenting Teens and Women Needs Assessment

Making the link between violence and health can improve efficiency and effectiveness by helping professionals focus on risk factors or behaviors that compromise a client’s health and discuss interventions that are most likely to succeed. For example, research has shown that women who were very knowledgeable about sexually transmitted infections (STIs) but were also very fearful of abuse were less likely to use condoms consistently than women who knew less about STIs but were not afraid of abuse (Ralford, DiClemente, & Wingood, 2009). Unless the role of abuse is addressed, further STI or HIV education is unlikely to lead to safer sex practices.

“A lot of women...struggle to find out which method would be best, and which one he would be okay with. They base their decision on what he says. They are genuinely worried about the relationship. ‘What would happen if I stray from [what he wants]? He would get really mad.’”

—Health Care Professional, 2012 Pregnant and Parenting Teens and Women Needs Assessment

An approach that integrates abuse issues with reproductive health care would inform clients about the increased risk of contracting STIs/HIV in abusive relationships, teach condom negotiation skills within the context of abusive relationships, and offer less detectable, birth control methods, thus leading to improved health outcomes and enhanced quality of care.

A health care professional working with a pregnant individual could integrate knowledge of abuse history with prenatal care by specifically asking clients what would make them more comfortable during a prenatal exam. For example, survivors may wish to have a very complete explanation of all procedures and for the professional to warn them before touching them. This is in keeping with the principles of trauma-informed services.

We show some examples of scripts that demonstrate harm reduction counseling when a client discloses IPV and/or reproductive and sexual coercion below.

We have also developed a one-page handout that clearly and effectively explains birth control methods that are less likely to be detected by an abusive partner. See **Birth Control Methods That Can Used Without a Partner’s Knowledge** in the Appendix.

What to Do if You Get a “Yes” to Pregnancy Pressure or Birth Control Sabotage

“I’m really glad you told me about what is going on. It happens to a lot of people and it is so stressful to worry about getting pregnant when you don’t want to be. I want to talk with you about some methods of birth control your partner doesn’t have to know about such as the IUD [with the strings cut short to avoid detection], Nexplanon [a birth control method implanted under the skin on the arm], and emergency contraception.”

What to Do if You Get a “Yes” to Difficulty Negotiating Condoms

“Many teens have talked to me about condoms breaking or coming off during sex. It’s awful when you have to worry about getting pregnant when you don’t want to be.”

“Even though condoms can prevent sexually transmitted infections, the safest and most reliable birth control method for you may be one that the person you are sleeping with can’t mess with. Have you ever thought about using the IUD or Nexplanon?”

“I want to make sure you know about the morning-after pill—emergency contraception so that you have back-up if the other methods don’t work. You may also want to have a plan for where to keep it—such as an empty pill bottle— so your partner won’t find the packaging.”

What to Do Regarding Partner Notification of a Positive STI

“I know it can be hard to talk about this – especially if you are worried your partner will blame you for the STI. What do you think will happen when they hear that they need to get treated? Are you worried that they might hurt you?”

“As you may know, we have to tell the people that you have slept with about the infection. There are a couple of ways we can do this to help you

- ▶ “We can talk to him about it in clinic and explain about transmission in case he gets angry or blames you.”
- ▶ “We can have someone call him anonymously from the health department saying that someone he has slept with in the past year has (name of STI) and he needs to come and be treated.”
- ▶ “If you decide you want to tell him yourself, you may want to tell him in a public place with lots of people around where you can leave easily if you need to.”

Offer Supported Referral

- ▶ Offer supported referral.

Supported referral is the other key strategy for addressing IPV and reproductive and sexual coercion as an integral part of health care. Supported referral is different from simply handing a client a card or suggesting that she make a call. Some elements of supported referral are:

- ▶ Health care professionals have taken the time to get to know the agencies and individuals to whom they refer clients.
- ▶ The health care professional can clearly explain what other service professionals can and cannot do for the client, thus lessening a client's frustration at reaching out for services that may not actually be available.
- ▶ The health care professional may be able to identify a specific person at another agency who is likely to be able to help the client.

“I refer a lot of people to [the advocacy program] but I think a really small percentage actually hook up with them. It would be nice to see those resources come to us. There’s that huge fear factor, ‘What is this? I have to make an effort to go out and see it. Do I know if it’s going to help me?’ ... I can bring [the behavioral health counselor] and say here is the person, she can help you with domestic violence, and that’s who they are going to go to. If I say, ‘Here is this phone number, this place is down there, take the bus,’ they are like ‘What? No.’ and that’s a big disconnect in those services.”

—Health Care Professional, 2012 Pregnant and Parenting Teens and Women Needs Assessment

- ▶ When appropriate, the health care professional may make a call on the client's behalf or help the client to make the call—for example, by calling the service professional, getting the right person on the phone, briefly explaining the situation, and then handing the phone to the client who can then ask a question or request an appointment. This may be particularly important with clients who are very young, who have limited English proficiency (in the absence of a bilingual professional to whom you can refer), or who are especially anxious. Of course, the client should sign a release of information form prior to any contact between the health care professional and another professional.

- ▶ The health care professional may ask the client whether there are any obstacles to following through with a referral, and brainstorm solutions with the client. Something as simple as providing a bus route map may make the difference in whether or not a client feels able to seek important services elsewhere.
- ▶ It may be helpful to remember how difficult it is for any of us to seek services for a sensitive or highly personal issue with an unknown professional. The more you know about the service professional to whom you are referring a client, the more you can convey your own confidence that this referral will be helpful. The advocates who participated in developing these guidelines emphasized the importance of personal connections in the Latin@ communities in which they work. Having a trusted community member or professional identify a referral is of utmost importance, particularly in communities where people may have had negative interactions with previous service providers or may not have connected with service providers in the past.

The first step in developing supported referral is to connect health professionals with existing support services for IPV and sexual assault in the community. Making this connection is mutually beneficial:

- ▶ Domestic violence and sexual assault advocates from shelters/advocacy programs are an excellent resource for training and advocacy.
- ▶ Domestic violence and sexual assault advocates will become more aware of what health services are available for survivors experiencing IPV and/or sexual assault.
- ▶ Health care professionals will become more familiar with what services for IPV and/or sexual assault are available locally and will have a specific person to contact when referring clients.

When making a supported referral, the professional may call the shelter or IPV/sexual assault program for a client or have the client call from the clinic. Helping clients link directly with domestic violence and sexual assault advocates while the clients are still in the health care setting can offer a safer option for individuals experiencing abuse. This approach can also increase the client’s comfort level when reaching out for assistance and increase the likelihood of following through with referrals.

Some clinics may wish to work with community-based advocacy agencies to create opportunities for advocates to meet clients at the health care facility, thus overcoming transportation and safety barriers. One of the advocacy programs in our pilot project was able to arrange for an advocate to be present when a survivor had a follow-up medical appointment, after the health care professional obtained permission from the patient at the previous appointment. In this particular case, the invited advocates were bicultural and bilingual, and their presence to support Latina survivors helped transcend language and cultural obstacles to obtaining advocacy services.

When working with pregnant or parenting individuals, other community referrals may also be appropriate. For example, you may wish to refer a woman to a doula or midwife who is experienced in working with survivors, or to refer a teen to a support group for teen parents. The same principles of supported referral would apply.

Sample Script

“I just want you to know that on the back of this safety card there are national hotline numbers with folks who are available 24/7 if you want to talk. They can connect you to local advocacy services if you need help. Advocates have worked with many people who are having a hard time in their relationship. Also, I know (insert name of local advocate)—she speaks Spanish and we can call together now if you would like to talk to her. The conversation is confidential and no one has to know that you have called.”

- ▶ Offer clients the use of a private phone in the clinic or office so they can call community-based services without being monitored by abusive partners.

Respect Their Answer

If They Say “Yes” to Relationship Problems but Don’t Disclose a Clear Description of Abuse or Coercion:

“You mentioned things are sometimes complicated in your relationship. I just want you to know that sometimes things can get worse. I hope this is never the case, but if you are ever in trouble, you can come here for help. I am also going to give you a card with a hotline number on it. You can call the number anytime. They really get how complicated it can be when you love someone and sometimes it feels unhealthy or scary. The hotline staff has contact with lots of women who have experienced this or know about it in a personal way.”

Understand Subtle Ways of Disclosing Abuse

Be aware that, in some cultures, the likelihood of a survivor identifying abuse directly is low. The bilingual/bicultural advocates who participated in this project said that survivors often said things like, “He failed to respect me,” when they were describing intimate partner sexual violence.

Safety Considerations for Clients Applying for Medicaid

Clients who apply for Medicaid coverage and other benefits are normally required to help the state pursue the collection of child support from the child’s other parent. However, there is a procedure called “Good Cause” that allows for exceptions in situations where pursuing child support might endanger the client and/or child. If your office or clinic encourages clients to apply for Medicaid, you can offer a real service by informing them of the Good Cause option. For more information, see Appendix E.

Appropriate Mental Health Referrals

Many adult and teen survivors can benefit from psychotherapy, and health care professionals outside of the mental health field frequently make referrals for mental health (sometimes called behavioral health) treatment within their clinic systems. Remember that trauma-informed services approach survivors with the understanding that their difficulties are mostly the result of what has happened to them, rather than what is “wrong” with them. Helping survivors understand that therapy is a way to enhance their coping skills rather than a way of “fixing” mental illness is critical.

Helping survivors understand that therapy is a way to enhance their coping skills rather than a way of “fixing” mental illness is critical.

If the professional is making a referral outside their health care setting for clients who have experienced abuse, in order to make a useful, appropriate referral, you need to know the mental health professionals and services in your community. Domestic violence and sexual assault programs often maintain resource lists of clinicians who have expertise in working with survivors.

It is important for medical professionals to link with mental health services for their patients: “It may not be in your face ‘I’m going through domestic violence.’ But it doesn’t take long to assess and find out where the depression is coming from. ... My experience with domestic violence is that if you probe and assess, it’s there.”

— *Behavioral Mental Health Specialist, 2012 Pregnant and Parenting Teens and Women Needs Assessment*

The Washington Coalition of Sexual Assault Programs (WCSAP) has created a guide called **What Advocates Need to Know About Therapy: Working with Children, Adolescents, and Families**. It is available for free download at <http://www.wcsap.org/what-advocates-need-know-about-therapy-working-children-adolescents-and-families>. While the guide is designed for advocates, any professional who works with pregnant or parenting individuals and wishes to link them to mental health services will find it useful. This guide explains the roles of different mental health professionals, discusses confidentiality and cultural competency, explains how to make a sensitive referral, and describes ways to promote positive relationships with mental health professionals in the community. Even if you have mental health resources on site, acquaint yourself with local mental health professionals who offer specialized treatment to abuse survivors; you may contact community-based advocacy programs for information about where to find appropriate therapy services.

If possible, seek to make a referral to a therapist who is fluent in your client's preferred language. While therapy can be conducted with an interpreter, the nature of the interaction makes this less than ideal. Because expression of thoughts and feelings is so important in therapy, survivors who are bilingual may still wish to have a therapist who speaks their preferred language.

Document

When a client discloses victimization or abuse is suspected, discuss and document follow-up to ensure continuity of care. In addition to offering appropriate referrals and assistance with contacting local resources such as a domestic violence or sexual assault advocate, ask the client if you can schedule a follow-up appointment at this time. It is also helpful to ask clients for contact information such as a phone number where it is safe to contact them so that any future contact will minimize risk to the client.

- ▶ Document screening, referral, and follow-up plans regarding IPV and sexual or reproductive coercion in each client's chart, along with safety considerations for contacting the client for follow-up.

Make sure all staff who may follow up with clients understand how to contact them safely and note in what language they are most comfortable communicating (that is, their preferred language). If you are able to select interpreters and your client has a preferred interpreter, make note of this as well. Whether your records are electronic or printed, develop a system for "flagging" records for clients who have safety concerns (similar to the way records are flagged for medication allergies). Be sure to clarify which, if any, phone numbers may be used for safe contact, and whether or not the client gives permission to leave a message. Train all staff to check for safety flags before attempting to contact a client for any reason.

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✓ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered YES to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

Getting Help

- ✓ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✓ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✓ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.

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Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233)

TTY 1-800-787-3224

www.thehotline.org

National Dating Abuse Helpline

1-866-331-9474

www.loveisrespect.org

National Sexual Assault Hotline

1-800-656-HOPE (1-800-656-4673)

www.rainn.org

**Did You
Know Your
Relationship
Affects Your
Health?**

Are you in a HEALTHY relationship?

Ask yourself:

- ✓ Is my partner kind to me and respectful of my choices?
- ✓ Does my partner support my using birth control?
- ✓ Does my partner support my decisions about if or when I want to have more children?

If you answered YES to these questions, it is likely that you are in a healthy relationship. *Studies show that this kind of relationship leads to better health, longer life, and helps your children.*

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✓ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✓ Does my partner refuse to use condoms when I ask?
- ✓ Does my partner make me have sex when I don't want to?
- ✓ Does my partner tell me who I can talk to or where I can go?

If you answered YES to any of these questions, your health and safety may be in danger.

Is your BODY being affected?

Ask yourself:

- ✓ Am I afraid to ask my partner to use condoms?
- ✓ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✓ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✓ Has my partner made me afraid or physically hurt me?

If you answered YES to any of these questions, you may be at risk for STD/HIV, unwanted pregnancies and serious injury.

Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✓ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✓ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✓ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.



¿Quién controla las decisiones de EMBARAZO?

Pregúntese. Mi pareja alguna vez:

- ✓ ¿Ha intentado presionarme o forzarme para que me embarace?
- ✓ ¿Me ha lastimado o amenazado porque no estoy de acuerdo en embarazarme?

Si alguna vez he estado embarazada:

- ✓ ¿Mi pareja me ha dicho que me lastimaría si no hacía lo que él quería con el embarazo (en cualquier dirección, continuar con el embarazo o aborto)?

Si respondió *Sí* a cualquiera de estas preguntas, no está sola y merece tomar sus propias decisiones sin tener miedo.

Obteniendo Ayuda

- ✓ Si su pareja revisa su teléfono celular o textos, hable con su proveedor de atención médica acerca de cómo usar su teléfono para llamar a los servicios de violencia doméstica, para que su pareja no pueda verlo en su registro de llamadas.
- ✓ Si tiene una enfermedad de transmisión sexual (ETS) y teme que su pareja la lastime si le dice, hable con su proveedor de atención médica acerca de cómo estar más segura y como ellos le pueden decir a su pareja de la infección sin usar su nombre.
- ✓ Estudios muestran que educar a sus amigos y familiares sobre el abuso puede ayudarles a tomar pasos para estar más seguros—dándoles esta tarjeta puede hacer una diferencia en sus vidas.

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The American College of Obstetricians and Gynecologists WOMEN'S HEALTH CARE PHYSICIANS

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Todas estas líneas nacionales pueden conectarla a recursos locales y brindarle apoyo. Para obtener ayuda 24 horas al día, llame al:

Línea Nacional Sobre la Violencia Doméstica
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

Línea Nacional de Maltrato entre Novios Jóvenes
1-866-331-9474
www.loveisrespect.org

Línea de Crisis Nacional de Abuso Sexual
1-800-656-4673
www.rainn.org

¿Sabía Que Su Relación Afecta Su Salud?



¿Está en una relación SANA?

Pregúntese:

- ✓ ¿Es mi pareja bueno conmigo y respetuoso de mis preferencias?
- ✓ ¿Apoya mi pareja mi uso de anticonceptivos?
- ✓ ¿Apoya mi pareja mis decisiones sobre si quiero y cuando quiero tener más hijos?

Si respondió *Sí* a estas preguntas, es probable que está en una relación sana. Estudios muestran que este tipo de relación conduce a una mejor salud, una vida más larga, y ayuda a sus hijos.

¿Está en una relación que NO ES SANA?

Pregúntese:

- ✓ ¿Mi pareja se entremete con mi anticonceptivo o trata de que quede embarazada cuando no yo quiero estar?
- ✓ ¿Mi pareja se niega a usar condones cuando se lo pido?
- ✓ ¿Mi pareja me hace tener relaciones sexuales cuando no quiero?
- ✓ ¿Mi pareja me dice con quién puedo hablar o dónde puedo ir?

Si respondió *Sí* a cualquiera de estas preguntas, su salud y seguridad pueden estar en peligro.

¿Está siendo afectado su CUERPO?

Pregúntese:

- ✓ ¿Tengo miedo pedirle a mi pareja que use condones?
- ✓ ¿Tengo miedo que mi pareja me lastime si le digo que tengo una infección de transmisión sexual (ITS) y él necesita tratamiento?
- ✓ ¿He escondido los anticonceptivos de mi pareja para que no me embarace?
- ✓ ¿Mi pareja me ha lastimado físicamente o le he tenido miedo?

Si respondió *Sí* a cualquiera de estas preguntas, puede estar en riesgo de ITS/VIH, embarazos no deseados, y lesiones graves.

Tomando Control:

Su pareja puede ver el embarazo como una forma de mantenerse en su vida y mantenerse conectado a través de un niño, aun cuando eso no es lo que usted desea.

Si su pareja le hace tener sexo, se entremete o altera su anticonceptivo, o se niega a usar condones:

- ✓ Hable con su proveedor de atención médica sobre anticonceptivos que usted pueda controlar (como el dispositivo intrauterino (DIU), implante anticonceptivo o inyección anticonceptiva).
- ✓ El DIU es un dispositivo seguro que se pone en el útero y evita un embarazo hasta por 10 años. Los hilos se pueden cortar para que su pareja no los sienta.
- ✓ Anticonceptivos de emergencia (unos le llaman la píldora de la mañana siguiente) se puede tomar hasta cinco días después de tener relaciones sexuales sin protección para evitar un embarazo. Se pueden sacar de su paquete y ponerlos en un sobre o botella de píldoras vacía para que su pareja no sepa.



What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- Make you feel safe and comfortable.
- Not pressure you or try to get you drunk or high because they want to have sex with you.
- Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.

How to Help a Friend

Do you have a friend who you think is in an unhealthy relationship?

Try these steps to help them:

- Tell your friend what you have seen in their relationship concerns you.
- Talk in a private place, and don't tell other friends what was said.
- Show them www.loveisrespect.org and give them a copy of this card.
- If you or someone you know is feeling so sad that they plan to hurt themselves and/or wish they could die—get help.
Suicide Hotline: 1-800-273-8255



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If you or someone you know ever just wants to talk, you can call these numbers. All of these hotlines are free, confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-866-331-9474 or online chat
www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

Rape, Abuse, Incest,
National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)



Hanging out or Hooking up?

How is it Going?

Does the person you are seeing (like a boyfriend or a girlfriend):

- ✓ Treat you well?
- ✓ Respect you (including what you feel comfortable doing sexually)?
- ✓ Give you space to hang out with your friends?
- ✓ Let you wear what you want to wear?

If you answered YES—it sounds like they care about you.

And on a Bad Day?

How often does the person you are seeing:

- ✓ Shame you or make you feel stupid?
- ✓ Pressure you to go to the next step when you're not ready?
- ✓ Control where you go, or make you afraid?
- ✓ Grab your arm, yell at you, or push you when they are angry or frustrated?

Nobody deserves to be treated this way. If these things ever happen in your relationship, talk to someone about it. For more info, go to www.loveisrespect.org.

Everybody Texts

Getting a lot of texts can feel good—"Wow, this person really likes me."

What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Figuring out what to say can be hard, especially if you like the person.

Be honest. "You know I really like you, but I really don't like it when you, text me about where I am all the time or pressure me for naked pics." For more tips on what to say go to: www.thatsnotcool.com.

What About Sex?

Can you talk to the person you are seeing about:

- ✓ How far you want to go sexually?
- ✓ What you don't want to do?
- ✓ Preventing STDs by using condoms?
- ✓ Birth control?

If you answered NO to any of these questions, maybe this person is pushing you to do things you don't want to do. Or you might not feel comfortable bringing this up. Try using this card as a conversation starter. "I got this card in a clinic and wanted to talk about it with you."



¿Qué hay del respeto?

La persona con quien estás (ya sea hablando, saliendo, o conectándote) debe:

- Hacerte sentir segura(o) y cómoda(o).
- No presionarte o tratar de emborracharte o drogarte para tener sexo contigo.
- Respetar tus límites y preguntar si puede tocarte o besarte (o cualquier otra cosa).

¿Cómo te gustaría que tu mejor amiga(o), o tu hermana(o) fuera tratada(o) por la persona con quien está saliendo? Pregúntate si la persona que tú estás viendo te trata con respeto y si tú le tratas con respeto.

Cómo Ayudar a Un(a) Amiga(o)

¿Crees que alguna(o) de tus amigas(os) está en una relación que no es buena para ella (él)?

Sigue estos pasos para ayudarla:

- Dile a tu amiga(o) que lo que has visto en su relación te preocupa.
- Habla con tu amiga(o) en privado, y no le cuentes a otras(os) amigas(os) lo que platicaron.
- Muéstrale www.loveisrespect.org y dale una copia de esta tarjeta.
- Si tú o alguien que tú conoces se siente tan triste que planea hacerse daño o desea morirse—busca ayuda. Red Nacional de Prevención del Suicidio: 1-800-273-8255

Si tú o alguien que tú conoces quisiera hablar acerca de su situación con personas que ofrecen apoyo, llama a estos números. Todas estas líneas directas son gratis y confidenciales, y puedes hablar con alguien sin tener que dar tu nombre.

Línea Nacional sobre el Abuso de Novios Adolescentes
1-866-331-9474
o plática/chattea (Chatroom) en Internet
www.loveisrespect.org

Red Nacional de Prevención del Suicidio
1-800-273-8255

Línea Directa Para Jóvenes que Huyen de Casa (National Runaway Switchboard)
1-800-621-4000

Red Nacional de Violación, Abuso, Incesto (RAINN)
1-800-656-Hope (1-800-656-4673)

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¿Saliendo o Conectando?

¿Cómo te va?

La persona con quien estás saliendo (como novio o novia):

- ✓ ¿Te trata bien?
- ✓ ¿Te respeta (incluyendo tus deseos y límites sexuales)?
- ✓ ¿Te da espacio para salir con tus amigas(os)?
- ✓ ¿Te deja vestirse como tú quieres?

Si contestaste SÍ—Parece que te aprecia.

¿Y en un día malo?

La persona con la que estás saliendo, qué tan seguido:

- ✓ ¿Te humilla o te hace sentir avergonzada(o)?
- ✓ ¿Te presiona a tomar el próximo paso cuando no estás lista(o)?
- ✓ ¿Controla a dónde vas, o te da miedo?
- ✓ ¿Te agarra por el brazo, te grita, o te empuja cuando está enojado(a) o frustrado(a)?

Nadie merece ser tratado de esta manera. Si alguna vez esto pasa en tu relación, habla con alguien sobre esto. Para más información, visita el sitio en el Internet www.loveisrespect.org.

Todos enviamos textos

Recibir muchos textos puede hacernos sentir bien—“¡Vaya, esta persona realmente me quiere.”

¿Qué pasa cuando los textos te hacen sentir molesta(o), nerviosa(o), o llegan sin parar?

Decidir qué vas a decir puede ser difícil, especialmente si te gusta esta persona.

Sé honesta(o). “Sabes que tú me gustas, pero a mí no me agrada cuando me mandas textos tan seguido, preguntándome dónde estoy o presionándome para que te mande fotos desnuda(o).” Para más consejos sobre qué decir, visita: www.thatsnotcool.com

¿Qué tal el sexo?

Puedes hablar con la persona con quien estás saliendo acerca de:

- ✓ ¿Hasta dónde quieres llegar sexualmente?
- ✓ ¿Lo que tú no quieres hacer?
- ✓ ¿El uso de condones para prevenir las infecciones de transmisión sexual (ITS)?
- ✓ ¿Métodos anticonceptivos?

Si contestaste NO a cualquiera de estas preguntas, quizás esta persona te está presionando a hacer cosas que tú no quieres hacer. O quizás no te sientes cómoda(o) tocando este tema. Trata de usar esta tarjeta para comenzar la conversación. “Recogí esta tarjeta en la clínica y quiero hablar contigo acerca de ella.”



Immigration and Documentation Status

Immigrant or undocumented survivors face discrimination and structural barriers that make it more difficult to be safe and seek help (see Part 1 for more information). These barriers include (Washington State Coalition Against Domestic Violence, 2011):

- ▶ Lack of language access
- ▶ Threat of deportation
- ▶ Isolation from community

Professionals working with these survivors should become familiar with the relief available under the Violence Against Women Act (VAWA). Specifically, the U-Visa provides documentation for survivors of specified crimes to remain in the country if they choose to work with law enforcement and the legal system to prosecute the crimes.

Resources

ASISTA

- ▶ For information on eligibility and certification for a U Visa, visit ASISTA's website at www.asistahelp.org/en/access_the_clearinghouse/. Asista provides centralized assistance for advocates and attorneys working with immigrant domestic violence and sexual assault survivors.

Tool Kit for Law Enforcement Use of the U-Visa

- ▶ www.vera.org/files/U-Visa-Law-Enforcement-Tool-Kit.pdf

U.S. Citizenship and Immigration Services (USCIS)

- ▶ **Victims of Criminal Activity: U Nonimmigrant Status**
<http://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-criminal-activity-u-nonimmigrant-status/victims-criminal-activity-u-nonimmigrant-status>
- ▶ **My Case Status**
Online USCIS dashboard - You can check your case status if you have a case number already.
<https://egov.uscis.gov/cris/Dashboard/CaseStatus.do>

Crossing Borders

- ▶ Crossing Borders is Washington State's multi-agency project created to support domestic violence and sexual assault programs to advocate effectively with immigrant, refugee, and limited-English-proficient survivors of violence. Crossing Borders' website contains valuable tools and resources for all professionals working with immigrant communities:
www.cbonline.org.

National Immigrant Women's Advocacy Project

- ▶ This searchable library of resources is designed to be used by OVW grantees and other advocates, attorneys, judges and service providers. The Technical Assistance section of this site provides OVW grantees and the general public access to questions frequently asked of Legal Momentum and an online Technical Assistance Request Form.
<http://iwp.legalmomentum.org>

Northwest Immigrant Rights Project (NWIRP)

- ▶ NWIRP provides a variety of direct services for immigrants and offers resources for immigrants and service providers.
<http://nwirp.org>

Tools for Healthcare Professionals

- ▶ **Reproductive Health Care Through the Eyes of Latina Women: Insights for Providers**
Child Trends
http://www.childtrends.org/wp-content/uploads/2013/03/Child_Trends-2012_08_31_FR_LatinaReproductive.pdf
- ▶ **Tools and Resources**
Migrant Clinicians Network
<http://www.migrantclinician.org/tools-and-resources.html>
- ▶ **Health Cares About IPV: Screening and Counseling Toolkit**
Futures Without Violence
<http://www.healthcaresaboutipv.org>



Part 6: Guidelines for Community-Based and Tribal Domestic Violence and Sexual Assault Advocates

Practice Guidelines for Community-Based and Tribal Domestic Violence and Sexual Assault Advocates

- ▶ Community-based domestic violence and sexual assault programs should develop a plan to enhance services for pregnant and parenting survivors, based on these guidelines.
- ▶ Tribal advocacy programs should develop and implement a plan to build awareness, support and understanding of reproductive coercion in Tribal communities working with Tribal Health Clinics and Tribal Council.
- ▶ Advocacy programs should develop and implement a plan to seek input from survivors and other community members to enhance their ability to address reproductive health and coercion in a culturally relevant way.
- ▶ Advocacy programs should display culturally and linguistically appropriate educational information and posters addressing reproductive coercion (including birth control methods that are less detectable by a partner, free pregnancy testing, and emergency contraception).
- ▶ Advocates (and volunteers, staff, board members, interpreters, and Tribal Council members) should receive initial and ongoing training on reproductive and sexual coercion that incorporates issues specific to Latin@ communities.
- ▶ Advocacy programs should participate in cross-training and build relationships with professionals who work with individuals during pregnancy and the first year after childbirth.
- ▶ As part of an intake process or an early conversation about services, advocates should offer all program participants information about emergency contraception, pregnancy tests, and birth control methods that are less detectable by a partner.
- ▶ As part of an intake process or an early conversation about services, advocates should ask pregnant survivors if they feel safe to make decisions about their pregnancy without fear of retribution (see Appendix B for additional information and sample questions).

- ▶ Advocates should provide a Futures Without Violence Safety Card (available in Spanish and English) to clients so that they are made aware of support and harm reduction options for their reproductive health.
- ▶ As part of the safety planning process, advocates should ask pregnant or parenting survivors if the abuse they have experienced is making it difficult to seek needed health care (see Appendix C for additional information and specific strategies).
- ▶ Advocacy programs should identify, build relationships with, and offer supported referrals to culturally or linguistically relevant community resources that are useful to pregnant and parenting survivors.
- ▶ Advocacy programs (preferably in conjunction with a community multidisciplinary group) should develop a simple referral handout about services specific to pregnant and parenting survivors and give it to clients and to community partners.

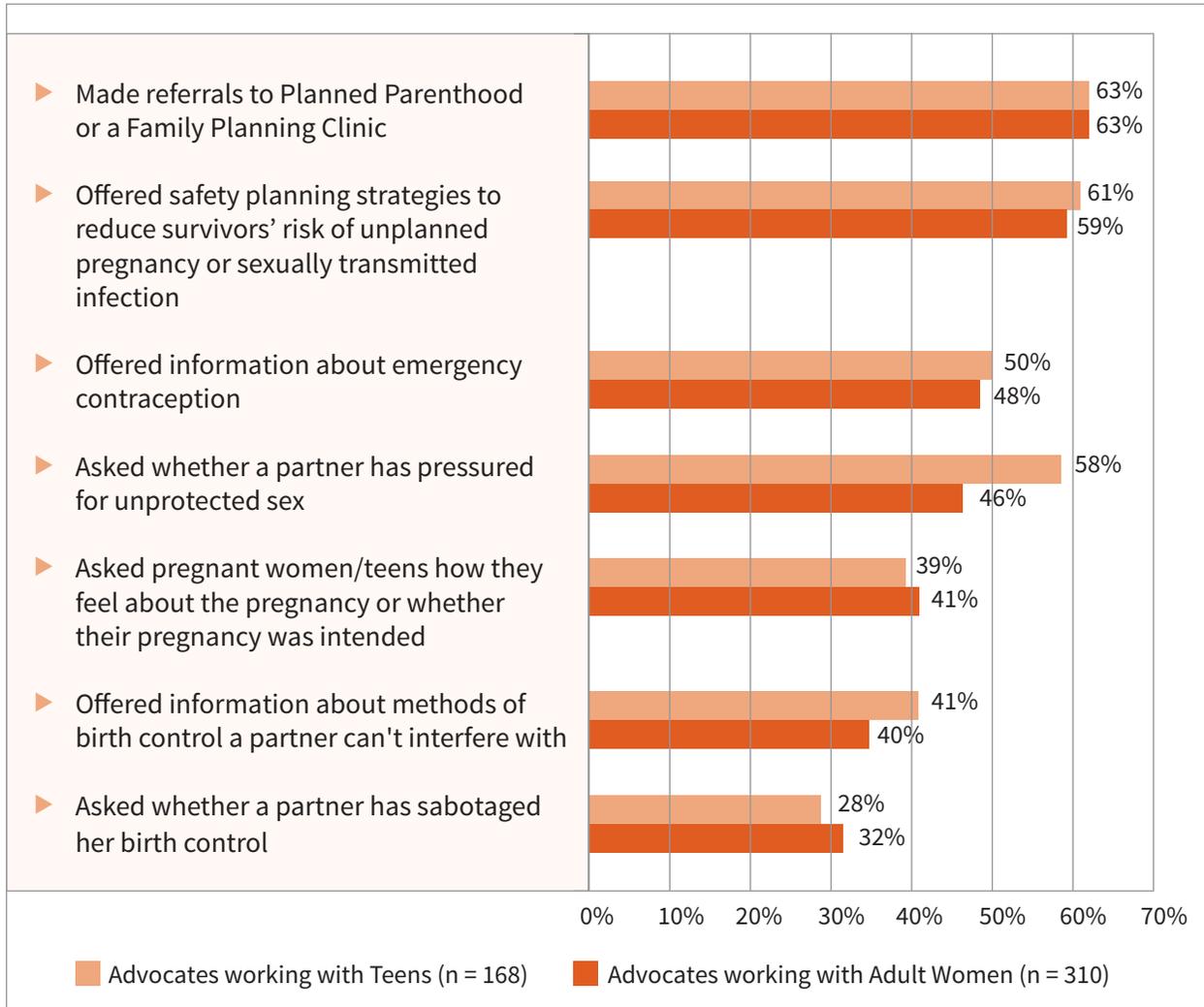
Introduction

These Practice Guidelines build on the existing knowledge of domestic violence and sexual assault programs. The guidelines seek to strengthen advocates' skills in identifying barriers to autonomy and safety for Latin@ survivors experiencing reproductive and sexual coercion. When survivors who are pregnant or have just given birth come to an advocacy program, they have a range of needs that advocates can address. For example, their traumatic experiences may affect what happens during childbirth, nursing, and parenting an infant. People in abusive relationships may have difficulty negotiating birth control with their partners and may become pregnant again sooner than they want to. When advocates ask the right questions, they have the opportunity to work with survivors and figure out the best strategies to support their reproductive health choices and, for some survivors, the experiences of pregnancy, childbirth, and parenting.

Many people who seek advocacy services have experienced reproductive and sexual coercion in their ongoing relationships. New developments in research and practice show that survivors benefit from specific attention to these issues (Miller, 2009). Therefore, expanding advocacy practices to address these all-too-common aspects of survivors' lives in a proactive manner allows for better understanding of the totality of their experiences.

In the 2012 Pregnant and Parenting Teens and Women Needs Assessment survey (WSCADV & WCSAP, 2012), most advocates reported using at least one strategy to address reproductive coercion with survivors. Advocates used similar strategies to address reproductive coercion, regardless of whether the survivor was an adult or a teen. Only 17% of advocates working with adults (n = 310) and 19% of advocates working with teens (n = 168) said they had not used any of the strategies listed.

How have you addressed reproductive coercion with survivors?



“Working with all advocacy programs is essential for building partnerships and offering meaningful services for survivors in mainstream, underserved and marginalized communities. You don’t have to work alone or do it all, it is important that everyone is at the table and all voices are heard when planning and offering services in culturally specific communities.”

—Debbie Hassler, Pathways to Healing, Program Manager, Cowlitz Indian Tribe, Member of the 2011-2013 Pregnant and Parenting Teens and Women Statewide Workgroup

The most common barrier advocates identified to addressing reproductive coercion with adult and teen survivors was “Survivors/Teens don’t want to talk about it.” Fifty percent of advocates who work with adults and 49% of advocates who work with teens cited this as a barrier. To support advocates in pursuing this specific focus, this section of the Practice Guidelines offers additional intake questions, safety planning strategies, and the simple intervention of providing the Safety Card developed by Futures Without Violence. Advocates can easily integrate these measures into their existing practices and forms.

Offering information about emergency contraception to a client who has just been raped is routine for most programs, but survivors who have had coerced unprotected sex may not be offered the same resources. Complicating matters further, advocates, volunteer staff, and board members may not believe programs should offer access to emergency contraception, or may not have an accurate understanding about how such emergency contraception works. For those programs that choose to provide information about emergency contraception, we strongly recommend that advocates receive training on this issue from their local health department, family planning clinic, or Planned Parenthood. See the information on Contraception and Birth Control Sabotage in Part 3: Reproductive Health Effects for a description of how advocacy agencies have reduced barriers for survivors to obtain emergency contraception when it is needed. Additional information and possible questions about emergency contraception are provided in Appendix D.

Prepare

Develop a Plan for Your Program

- ▶ Community-based domestic violence and sexual assault programs should develop a plan to enhance services for pregnant and parenting survivors, based on these guidelines.
- ▶ Tribal advocacy programs should develop and implement a plan to build awareness, support and understanding of reproductive coercion in Tribal communities working with Tribal Health Clinics and Tribal Council.
- ▶ Community-based domestic violence, sexual assault and Tribal advocacy programs should develop and implement a plan to seek input from survivors and other community members to enhance their ability to address reproductive health and coercion in a culturally relevant way.

“A lot of my [Latina] clients say ‘He failed to respect me’ as a code for ‘There was an assault,’ or ‘I didn’t want to and I had to anyway.’ It’s like they say it and they want to know if I catch on, do I get it? [If I say] ‘Oh, did that happen?’ They say, ‘Yeah, that happened,’ and explain it. But maybe if I didn’t catch on, if I didn’t know what that phrase meant, they wouldn’t go into it. They don’t want to say, ‘I was raped; I was sexually assaulted’ but if they can say it in a way that sounds less harsh, they’re more comfortable opening that door and talking about it.”

—Advocate, 2012 Pregnant and Parenting Teens and Women Needs Assessment

A simple, brief plan that includes specific procedures for incorporating action steps based on these Practice Guidelines will be helpful in training and orienting staff, as well as sharing your approach to working with pregnant and parenting clients with others such as your Board of Directors and community partners.

Create a Supportive Environment

- ▶ Advocacy programs should display culturally and linguistically appropriate educational information and posters addressing reproductive coercion (including birth control methods that are less detectable by a partner, free pregnancy testing, and emergency contraception).

Having these materials on display will help clients feel comfortable to discuss their concerns.

- ▶ Futures Without Violence provides several posters in English and Spanish that you can get for free or download from their online store: https://secure3.convio.net/fvpf/site/Ecommerce/1521540250?VIEW_PRODUCT=true&product_id=1172&store_id=1241
- ▶ Planned Parenthood has a Spanish-language guide to help parents discuss sexuality with their children, **¿Y Entonces, Qué Digo?** It is available at <http://www.plannedparenthood.org/nyc/files/NYC/ParentGuideSp.pdf>
- ▶ The Washington Coalition of Sexual Assault Programs has a growing number of resources in Spanish. For the most up-to-date list, go to www.wcsap.org and click on the Español button on the top of the home page.
- ▶ The King County Sexual Assault Resource Center has a number of publications on sexual abuse and assault available in Spanish at <http://www.kcsarc.org/dandovozenespanol#publications>
- ▶ The Women’s Justice Center (Centro de Justicia para Mujeres) has an extensive collection of Spanish-language resources for advocates and survivors at http://justicewomen.com/tips_index_spanish.html
- ▶ The Office of Justice Programs’ Existe Ayuda Toolkit offers materials for advocates and survivors at <http://www.ovc.gov/pubs/existeayuda/about/products.html>
- ▶ Planned Parenthood has health resources in Spanish: <http://www.plannedparenthood.org/esp/>

Train

Training on Reproductive and Sexual Coercion

Training introduces advances in the field and offers opportunities for staff to discuss progress, challenges, and opportunities.

- ▶ Advocates (and volunteers, staff, board members, interpreters, and Tribal Council members) should receive initial and ongoing training on reproductive and sexual coercion.
- ▶ Advocacy programs should participate in cross-training and build relationships with professionals who work with individuals during pregnancy and the first year after childbirth.

In the Statewide Needs Assessment survey of domestic violence and sexual assault advocates, 38% of respondents working with adults and 33% working with teens identified the need for more training as a barrier to talking about reproductive coercion with survivors (WSCADV & WCSAP, 2012).

For advocacy programs that are part of multi-service agencies, training on intimate partner violence, sexual assault, sexual harassment, and stalking could be offered to staff in different departments, such as receptionists, front office staff, security guards, and parking lot attendants who may observe abusive and/or threatening behaviors and have safety concerns for clients.

In addition to cross-training with more traditional health care professionals, think “outside the box” to develop cross-training with doulas, midwives, childbirth educators, prenatal yoga or exercise instructors, lactation specialists, and others who interact with pregnant and parenting individuals.

Training Resources for Reproductive Coercion

Health Cares About IPV: Intimate Partner Violence Screening and Counseling Toolkit is a free toolkit developed by Futures Without Violence (2013). It can be used for self-directed training and to provide training to your staff (download at <http://www.healthcaresaboutipv.org>). Under "Getting Started," you can access training resources including videos and a wide variety of written information. There are resources that are customized for particular health settings, such as reproductive health, Indian health, and mental health. On the training page, you can find **Making the Connection: Intimate Partner Violence and Public Health**, a free resource that consists of a PowerPoint presentation, speaker's notes, and an extensive bibliography. It addresses the following reproductive health-related topics:

- ▶ IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
- ▶ IPV and Sexually Transmitted Infections/HIV
- ▶ IPV and Women's Health

Free eLearning Activity: Online education opportunities on violence and reproductive and sexual coercion are also available. Go to www.futureswithoutviolence.org for information on new training opportunities as they become available.

The **Washington Coalition of Sexual Assault Programs** has relevant training available in its E-Learning Center and on its recorded webinars page. Check the Training and Events tab at www.wcsap.org.

The **Washington State Coalition Against Domestic Violence** also has an E-Learning Center at www.wscadv.org, under Training and Events.

Both Coalitions collaborate on the Crossing Borders Project, which offers advocacy tools for working with and on behalf of immigrant and refugee survivors: www.cbonline.org.

Inform

Working with Interpreters

When a survivor receives advocacy in their own language, advocacy programs are providing the best access to information and resources. When that is not possible, interpreters can be a critical part of increasing a survivor's access to services and in supporting advocacy. Advocates can support a survivor's access to services by hiring the interpreter preferred by the survivor. For survivors, the preferred interpreter will communicate most effectively in the survivor's language, respect their confidentiality, and maintain their professional boundaries. During the advocate's first interaction with the survivor, if the advocate does not speak the survivor's language, it can be challenging to find out who might be the best interpreter. Advocates suggest using a service such as Language Line Services, an accompanying bilingual friend or family member, or a written question in the client's language for those who are literate (<http://www.lep.gov/ISpeakCards2004.pdf>). These options are not a replacement for the presence of a professional interpreter for ongoing services, but may be useful just to identify the best interpreter to fit the survivor's needs.

The advocate should also check to see if the survivor knows the hired interpreter; and, if needed, offer to hire an interpreter from another community. Advocates involved in the 2012 Needs Assessment mentioned that they contacted the Washington State Court Interpreter Program when they needed to find an interpreter for less commonly used languages in their area (http://www.courts.wa.gov/programs_orgs/pos_interpret/).

“Include a specific description of the bilingual services offered. For example, replace ‘services offered in Spanish’ with a detailed list of specifically which services are provided. This should be written in Spanish on all agency materials and Web sites (e.g., Servicios que se ofrecen en español).”

(Office for Victims of Crime, 2011, p. 3).

Even though interpreters are legally required to maintain confidentiality, some programs ask interpreters to sign a confidentiality agreement before working with the survivor to emphasize the importance of the survivor's safety and control of their information. The survivor's perception that their advocate will keep their information confidential is extremely important. Therefore, you may wish to reiterate highlights of the interpreter confidentiality agreement verbally in the presence of the survivor – “Rosa is here to interpret for us today. She has signed a confidentiality agreement saying that what is said today is private, and she will not repeat it to anyone.”

Programs should be cautious about simply translating written materials intended for survivors and for the community in general without scrutinizing the new version for cultural appropriateness. A poorly translated document or one that is not culturally appropriate may do more harm than good. Like many other languages, Spanish is not universal across all countries. Some words used in one country may be different, not understandable, or offensive to individuals from another country. All materials that are translated into Spanish should use words that are universally appropriate to all Latin American Spanish-speaking countries (also known as Broadcast Spanish) to ensure the materials can be understood by the greatest range of individuals. If there are no bilingual/bicultural advocates on staff to review these materials, Latin@ community partner organizations may be willing to take a look and provide feedback.

For more extensive information about interpreters and language access, see Part 2: Trauma-Informed Services.

Bilingual/Bicultural Advocates

Bilingual/bicultural advocates who can provide direct services and community outreach are a vital asset for domestic violence and sexual assault advocacy programs working in Latin@ communities (Office for Victims of Crime, 2011). While advocates who are fluent in Spanish but not Latin@ can certainly offer valuable services, the advocates and health care professionals who worked on this project told us that bilingual/bicultural advocates are more often seen as trusted community members who may be able to connect more readily with survivors.

In Washington State, the Crossing Borders Project (www.cbonline.org) is a collaborative effort of the Washington State Coalition Against Domestic Violence and the Washington Coalition of Sexual Assault Programs to enhance advocacy for immigrant and refugee survivors and those with limited English proficiency.

Listening to Survivors Tell Their Stories

One theme of the 2012 Pregnant and Parenting Teens and Women Needs Assessment was the ability of advocates to identify survivors' needs by listening to survivors tell their stories. Survivors rarely show up with checklists of what they need; rather their needs emerge from telling the story of their abuse. The advocate has the training and knowledge of resources to help survivors determine what advocacy they may need.

Advocates shared stories of survivors' experiences of sexual and reproductive coercion that revealed a range of advocacy needs including:

- ▶ Information about options for preventing pregnancy and sexually transmitted infections
- ▶ Strategies for deescalating sexual violence
- ▶ Strategies for talking to their children about sexual coercion
- ▶ Strategies for talking to teens about sexual coercion
- ▶ Options for legal advocacy in the context of parenting plans and custody, and information about legal rights in the Good Cause exception process when establishing paternity

Don't Ask, Just Tell! Offering Information at Intake about Reproductive Health

In the Pregnant and Parenting Teens and Women Needs Assessment interviews (WSCADV & WCSAP, 2012), domestic violence advocates reflected that survivors often did not talk about experiences of sexual coercion right away. Advocates described the importance of being ready to hear about all the complex and conflicted feelings that survivors express, such as shame, guilt, and confusion.

“She thought... ‘Maybe I deserved it because I had sex with him and I shouldn't have been having sex with him.’ ... and ‘Well, I consented to the other sex so doesn't that mean that I deserved to have that happen to me as well?’ As she gained trust around hearing that it wasn't her fault and...that, no, she didn't consent to it, and that I believed that, it helped her to open up further and share more of that story that she felt intense shame about.”

—Advocate, 2012 Pregnant and Parenting Teens and Women Needs

Advocates in the Needs Assessment told us that they felt they needed to follow the survivor's lead, build trust, and wait for a disclosure of abuse or unprotected or unwanted sex. Certainly it can be difficult to discuss such sensitive issues before trust has been established in the advocacy relationship. This is where the “Don't Ask, Just Tell!” approach is so valuable. Rather than waiting for clients to disclose or asking questions that may be perceived as intrusive early in the advocacy process, advocates can simply offer timely information that may have far-reaching positive consequences for survivors. When clients learn during intake or an initial advocacy conversation that the advocate can provide information and resources about emergency contraception or less detectable birth control options, they can make informed choices that could prevent an unintended pregnancy then or in the future.

As we have described in Part 1 of this document, offering universal information about the availability of emergency contraception, pregnancy tests, and birth control methods that are less likely to be felt or interfered with by a partner is a powerful intervention. Given the limited window of opportunity to take emergency contraception, offering this information early supports a survivor's autonomy and choices over their reproductive health. Both Coalitions have developed tools and training to enhance advocates' knowledge about hidden forms of birth control and emergency contraception (see Appendices I & J).

Questions and Safety Planning Strategies

By offering information and adding simple questions to the intake process, advocates can proactively create an environment that allows for deeper conversation with the survivor regarding safety and decision-making.

- ▶ As part of an intake process or an early conversation about services, advocates should offer all program participants information about emergency contraception, pregnancy tests, and birth control methods that can be used without a partner's knowledge.
- ▶ As part of an intake process or an early conversation about services, advocates should ask pregnant survivors if they feel safe to make decisions about their pregnancy without fear of retribution (see Appendix B for additional information and sample questions).
- ▶ Advocates should provide a Futures Without Violence Safety Card to clients so that they are made aware of support and harm reduction options for their reproductive health.
- ▶ As part of the safety planning process, advocates should ask pregnant or parenting survivors if the abuse they have experienced is making it difficult to seek needed health care (see Appendix C for additional information and specific strategies).

In the 2012 Pregnant and Parenting Teens and Women Needs Assessment interviews (WCSAP & WSCADV, 2012), advocates observed that teens who are unsafe at home or hiding their sexual relationships are at an increased risk for continued abuse and sexual coercion. Teens often feel they have nowhere to go for help and do not think of domestic violence advocacy programs as a resource nor do they think of domestic violence shelter programs as an option for emergency housing. In Washington State, teens under the age of 18 can receive advocacy services but a teen must be 18 or older to be housed at a domestic violence emergency shelter.

Abusers may manipulate decisions regarding reproductive health and parenting, which can affect survivors' autonomy and safety. Trauma-informed safety planning strategies can support survivors' ability to anticipate abusers' reactions and plan for their own safety.

Safety planning with teens involves a complex set of issues. Teens in abusive relationships who are also not safe at home with their parents or guardians will have fewer options and be more vulnerable to abusers' coercion. They may be more likely to get pregnant and consequently, become more dependent on a controlling partner. A young teen living with an adult abuser or with parents will have different needs from adult survivors who can legally be on their own, and are able to seek financial resources. Teens in abusive relationships may need help to figure out which living situation—living at home, with another family member, or with a friend's parent—increases their safety, choices, and resources.

“There was a teenage gal with a controlling boyfriend; she wanted out of that relationship. Her father was angry because she was pregnant, and beat her, trying to force an abortion. She was at the hospital, not safe to go home and didn’t want to go with the boyfriend.”

—Advocate, 2012 Pregnant and Parenting Teens and Women Needs Assessment

These guidelines are designed to enhance survivor safety and access to critical health care services. Once advocates have asked about health concerns, they can work with survivors to provide targeted safety planning and to offer appropriate referrals.

Futures Without Violence has developed safety cards on reproductive coercion and violence. The Safety Card **Did You Know Your Relationship Affects Your Health?** offers a method for opening the conversation between advocates and survivors about IPV and reproductive and sexual coercion. It also allows the advocate to introduce important information about contraceptive harm reduction strategies.

A teen Safety Card, entitled **Hanging Out or Hooking Up?** is also available. The teen card does not go into detail about contraceptive harm reduction strategies, but it does cover issues associated with unhealthy relationships, including electronic harassment and sexual decision-making.

You can download or order hard copies of these resources, available in English and Spanish, through the Futures Without Violence website (https://secure3.convio.net/fvvpf/site/Ecommerce/567623699?FOLDER=1133&store_id=1241). The cards are free, with just a minimal shipping charge. Samples of these cards are included in this document on pages 97–100.

These cards are designed for clients to answer questions about their relationships, including whether their partners are interfering with their ability to make choices about their reproductive health. Approximately the size of a business card, the Safety Cards include:

- ▶ Questions about elements of health and unhealthy relationships
- ▶ Questions asking whether they experience IPV, birth control sabotage, pregnancy pressure, forced sex, and other controlling behaviors
- ▶ Suggestions for what to do if they are experiencing IPV and/or reproductive coercion
- ▶ Hotline numbers

Sample Script in Spanish
Provided by Bilingual/Bicultural Advocates in the Project
(one example of how to introduce the card)

Hemos empezado a repartir estas tarjetas a todos nuestros clientes. Esta tarjeta es como un cuestionario de magazine. Se habla de relaciones saludables, seguras. También habla de maneras en que su relación puede afectar su salud. Si usted o alguien que conoce tiene alguna pregunta sobre la tarjeta le podemos dar información de algunas agencias o clínicas en nuestra área. Si usted o alguien que conoce gusta, le podemos ayudar hacer una cita hoy. Usted también puede compartir estas tarjetas con sus amistades.

We have a card that we've been handing out to all of our clients. It's similar to a quiz you would take in a magazine. It has valuable information not only for you but also for friends and family. This card talks about what a healthy and safe relationship should look like. It discusses your health and the effects it may have on your relationship. If at any time you or someone you know has questions or concerns about this card, please feel free to ask so that I may be able to connect you with the right people and/or agencies in our area to answer those questions and/or concerns. If you would like, I can also assist you or someone you know in making an appointment.

Refer

Develop a Culturally-Grounded Community Support and Referral Network

- ▶ Advocacy programs should identify, build relationships with, and offer supported referrals to culturally or linguistically relevant community resources that are useful to pregnant and parenting survivors.

“We have a public health nurse who comes in weekly and can provide family planning and reproductive consultation and make arrangements for our residents at her clinic.”

—Advocate, 2012 Pregnant and Parenting Teens and Women Needs Assessment

A culturally-grounded approach includes interventions that “affirm and strengthen families’ [and individuals’] cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society (Marsiglia & Kulis, 2009, p. 204).

“Carla” is a pregnant survivor of both childhood sexual abuse and rape as an adult. She has intense fears about childbirth. Her advocate introduces her to a local midwife who helps Carla to develop a birth plan so she can look forward to her baby’s birth with considerably less worry.

Culturally-grounded referrals take into consideration the specific needs of survivors from a particular community. These resources include health care professionals, family planning and Maternity Support Services, Planned Parenthood clinics, Migrant Farmworkers’ clinics, immigrant and refugee services, and Tribal Health clinics. See Part 3: Reproductive Health Effects for more information on building partnerships with other professionals who work with pregnant and parenting individuals.

Survivors who are pregnant or have babies can truly benefit from supported referrals to trauma-informed childbirth educators, doulas, midwives, obstetricians, nurses, breastfeeding peer counselors, lactation specialists, and clinics.

A supported referral paves the way for a survivor to feel comfortable in obtaining needed services. Attempt to make a face-to-face connection with a local health care professional or your community clinic -- make a coffee date, or invite providers to your agency.

Provide a Referral Handout

- ▶ Advocacy programs (preferably in conjunction with a community multidisciplinary group) should develop a simple referral handout about services specific to pregnant and parenting survivors and give it to clients and to community partners such as law enforcement and prosecutors.

“This lady had a husband and had insurance but he forbid her from using birth control. So I referred to her to Planned Parenthood...and she’s using birth control without him knowing. So there’s pressure, ‘Why aren’t you pregnant again? My brother got his wife pregnant, so I don’t want people to think I’m less than him.’”

—Advocate, 2012 Pregnant and Parenting Teens and Women Needs Assessment

On ParentHelp123.org, a program of WithinReach (or on its sister site, WashingTeenHelp.org, geared to teens), the advocate can create a personalized resource list with the survivor at <https://resources.parenthelp123.org/>. At this time, these resources are available in English only, but the hotline listed on the website offers assistance in both English and Spanish.

To allow clients to follow up on referrals, it is helpful to give them a written handout with information about local resources and contact information along with the Safety Card. While most programs already have comprehensive referral information, this list will focus on trauma-informed local services that offer additional support to pregnant and parenting clients, such as doulas and midwives, reproductive health clinics, lactation support, WIC, and parenting support resources. It will be helpful to update your resource lists to indicate which services are available in languages other than English.

Survivors may not be ready to follow through on a referral immediately after contact with an advocate, and having this information in writing will make it easier for them to locate resources when they are ready to use them.

Immigration and Documentation Status

Immigrant or undocumented survivors face discrimination and structural barriers that make it more difficult to be safe and seek help (see Part 1 for more information). These barriers include (Washington State Coalition Against Domestic Violence, 2011):

- ▶ Lack of language access
- ▶ Threat of deportation
- ▶ Isolation from community

Professionals working with these survivors should become familiar with the relief available under the Violence Against Women Act (VAWA).

Fears About Documentation Status

Undocumented survivors may be reluctant to follow through on a health care referral because of concerns about their documentation status. Advocates may wish to say something like:

- ▶ Just so you know, health professionals and clinic staff **CANNOT** ask you about your documentation status or if you “have papers.” You can receive many services for free or at low cost.

Note: Tribal clinics do ask for documentation of Native status; individuals must have documentation to receive services.

Resources

ASISTA

- ▶ For information on eligibility and certification for a U Visa, visit ASISTA's website at www.asistahelp.org/en/access_the_clearinghouse/. Asista provides centralized assistance for advocates and attorneys working with immigrant domestic violence and sexual assault survivors.

Tool Kit for Law Enforcement Use of the U-Visa

- ▶ www.vera.org/files/U-Visa-Law-Enforcement-Tool-Kit.pdf

U.S. Citizenship and Immigration Services (USCIS)

- ▶ **Victims of Criminal Activity: U Nonimmigrant Status**
<http://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-criminal-activity-u-nonimmigrant-status/victims-criminal-activity-u-nonimmigrant-status>
- ▶ **My Case Status**
Online USCIS dashboard - You can check your case status if you have a case number already.
<https://egov.uscis.gov/cris/Dashboard/CaseStatus.do>

Crossing Borders

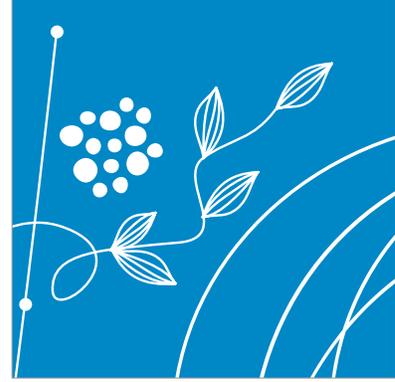
- ▶ Crossing Borders is Washington State's multi-agency project created to support domestic violence and sexual assault programs to advocate effectively with immigrant, refugee, and limited-English-proficient survivors of violence. Crossing Borders' website contains valuable tools and resources for all professionals working with immigrant communities: www.cbonline.org.

National Immigrant Women's Advocacy Project

- ▶ This searchable library of resources is designed to be used by OVW grantees and other advocates, attorneys, judges and service providers. The Technical Assistance section of this site provides OVW grantees and the general public access to questions frequently asked of Legal Momentum and an online Technical Assistance Request Form.
<http://iwp.legalmomentum.org>

Northwest Immigrant Rights Project (NWIRP)

- ▶ NWIRP provides a variety of direct services for immigrants and offers resources for immigrants and service providers.
<http://nwirp.org>



Part 7: Resources

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Appendices

Appendix A: List of Practice Guidelines

Practice Guidelines for All Professionals Working with Teens

(Select the guidelines appropriate for your professional role.)

- ▶ Teens have a unique lingo, so ask teen clients what they mean if you are not 100% sure.
- ▶ Use gender-neutral terms when talking about teens' dating partners.
- ▶ Learn about the relevant state laws related to age of consent.
- ▶ Ask teens for feedback on whether your agency projects a teen-friendly atmosphere.
- ▶ Provide staff training on how to offer a welcoming experience to teen clients.
- ▶ Identify the school-based programs that serve pregnant or parenting teens in your community (GRADS programs or other local school or community programs).
- ▶ Call or visit the teachers and other key school personnel to provide information about your services for teen survivors.
- ▶ Offer to provide in-service training or to participate in a training exchange with school-based service providers on IPV, sexual and reproductive coercion, and trauma-informed approaches to teens.
- ▶ Know your state laws and agency policies about confidentiality and mandated reporting.
- ▶ Have a standard statement about confidentiality that you say to teens during your intake process.
- ▶ Learn about mandated reports regarding the children of teen parents. Exposure to domestic violence does not constitute child abuse or neglect.
- ▶ Make sure you have the knowledge and resources to assist with safety planning prior to making a mandatory report.

Practice Guidelines for Health Care Providers

- ▶ Have a private place to interview clients alone where conversations cannot be overheard or interrupted.
- ▶ Display culturally and linguistically appropriate educational information (addressing IPV, reproductive coercion, stalking, and sexual assault), including posters, hotline numbers, safety cards, screensavers, and resource cards, in common areas and in private locations such as bathrooms and exam rooms.
- ▶ Develop a written training policy and provide staff training on IPV, sexual assault, and reproductive coercion, including the appropriate steps to inform clients about the limits of confidentiality and reporting requirements.
- ▶ Develop referral lists and create partnerships with local diverse service providers and resources. Establish relationships with local community-based domestic violence and sexual assault advocacy programs so that you can make informed referrals and possibly collaborate on training activities.
- ▶ Integrate core training on relationship and abuse issues (including specific training on IPV, sexual assault and coercion, stalking, and reproductive coercion) at general trainings for all clinic staff who have contact with clients.
- ▶ Advanced skills-based training should be offered on an ongoing basis and should cover how to seamlessly integrate assessment and brief intervention into current practice.
- ▶ Always disclose limits of confidentiality prior to doing any assessment with clients.

- ▶ Professionals and staff should use the Futures Without Violence Safety Card for Reproductive Health to facilitate screening and educate clients about healthy relationships and the impact of IPV and reproductive and sexual coercion on health.
- ▶ Offer visit-specific harm reduction strategies.
- ▶ Offer supported referral.
- ▶ Offer clients the use of a private phone in the clinic or office so they can call community-based services without being monitored by abusive partners.
- ▶ Even if you have mental health resources on site, acquaint yourself with local mental health professionals who offer specialized treatment to abuse survivors; you may contact community-based advocacy programs for information about where to find appropriate therapy services.
- ▶ Document screening, referral, and follow-up plans regarding IPV and sexual or reproductive coercion in each client's chart, along with safety considerations for contacting the client for follow-up.

Practice Guidelines for Community-Based and Tribal Domestic Violence and Sexual Assault Advocates

- ▶ Community-based domestic violence and sexual assault programs should develop a plan to enhance services for pregnant and parenting survivors, based on these guidelines.
- ▶ Tribal advocacy programs should develop and implement a plan to build awareness, support and understanding of reproductive coercion in Tribal communities working with Tribal Health Clinics and Tribal Council.
- ▶ Advocacy programs should develop and implement a plan to seek input from survivors and other community members to enhance their ability to address reproductive health and coercion in a culturally relevant way.
- ▶ Advocacy programs should display culturally and linguistically appropriate educational information and posters addressing reproductive coercion (including birth control methods that are less detectable by a partner, free pregnancy testing, and emergency contraception).
- ▶ Advocates (and volunteers, staff, board members, interpreters, and Tribal Council members) should receive initial and ongoing training on reproductive and sexual coercion that incorporates issues specific to Latin@ communities.
- ▶ Advocacy programs should participate in cross-training and build relationships with professionals who work with individuals during pregnancy and the first year after childbirth.
- ▶ As part of an intake process or an early conversation about services, advocates should offer all program participants information about emergency contraception, pregnancy tests, and birth control methods that are less detectable by a partner.
- ▶ As part of an intake process or an early conversation about services, advocates should ask pregnant survivors if they feel safe to make decisions about their pregnancy without fear of retribution (see Appendix B for additional information and sample questions).

- ▶ Advocates should provide a Futures Without Violence Safety Card (available in Spanish and English) to clients so that they are made aware of support and harm reduction options for their reproductive health.
- ▶ As part of the safety planning process, advocates should ask pregnant or parenting survivors if the abuse they have experienced is making it difficult to seek needed health care (see Appendix C for additional information and specific strategies).
- ▶ Advocacy programs should identify, build relationships with, and offer supported referrals to culturally or linguistically relevant community resources that are useful to pregnant and parenting survivors.
- ▶ Advocacy programs (preferably in conjunction with a community multidisciplinary group) should develop a simple referral handout about services specific to pregnant and parenting survivors and give it to clients and to community partners.

Appendix B: Intake Questions for Advocates

Advocacy programs may consider incorporating some of these questions into their intake process. The decision of which questions to use should be informed by the program's purpose and wishes as well as the situation and needs of a particular survivor.

Sexual Coercion Intake Questions

- ▶ Do you feel your partner listens to what you want in your sexual relationship and respects your decisions?
- ▶ Have you ever had a past relationship where you felt your sexual wishes were not respected? If so, how do you think that's affecting things for you now?
- ▶ Does your partner currently pressure you to do things sexually that you are not comfortable with?
- ▶ Is there anything else that you are concerned about that we haven't yet talked about?

Pregnancy Coercion Intake Questions

- ▶ Are you pregnant?
- ▶ If pregnant, how do you feel about your pregnancy?
- ▶ Are you concerned about anyone else's reactions to your pregnancy?
- ▶ Do you have support as you go through this, and from whom?
- ▶ What do you want to do about this pregnancy?

Reproductive Coercion Intake Questions

- ▶ Can you talk to your partner openly about birth control?
- ▶ Does your partner listen to what you want to do about birth control?
- ▶ Are you aware that there are some methods of birth control that your partner doesn't have to know about (can't see or feel)? Do you want more information about your options? [if so, make referral to health care provider]

Reproductive Health Services Intake Questions

- ▶ Patients have the right to consent to reproductive health care at any age in Washington State. Parental consent is not required.
- ▶ Did you know there is free or low cost testing for (pregnancy, STD, HIV) in our community?
- ▶ Would you like me to call the clinic and help you make an appointment?
- ▶ If you want us to, I can go with you to the clinic for your appointment.
- ▶ If you do not want to go to a provider in our community, we can find another clinic outside our county/city.

Perinatal Intake Questions

- ▶ Do you have any particular concerns or worries about your pregnancy, childbirth, or taking care of your new baby?

Trauma History Impact Questions

- ▶ Has anything that has happened to you during your life made it difficult for you to go to the doctor or be in the hospital?
- ▶ Do you have any worries about your pregnancy, childbirth, or breastfeeding because of your past experiences?

Appendix C: Trauma-Informed Safety Planning Strategies for Advocates

Sample safety planning questions are provided below. These questions range from simple ones that you may already be using in your program to more nuanced safety planning strategies for the unique concerns of pregnant and parenting survivors.

Trauma-Informed Emotional Safety Planning Questions

You mentioned some concerns about receiving health care because of things that have happened to you.

- ▶ Would you like to make a plan with a health care provider for pregnancy checkups, childbirth, or breastfeeding concerns?
- ▶ We know some wonderful doulas and midwives in the area who work with women who have had difficult experiences. They help them make plans so that their pregnancy, childbirth, and parenting experiences go more smoothly. Would you like to see one of these doulas or midwives for more in-depth planning around these issues?

Reproductive and Sexual Coercion Safety Planning Questions

- ▶ Is there something that has helped when your partner pressured you to do things sexually that you were not comfortable with?
- ▶ Is there anyone you feel like you can talk to about the sexual coercion or abuse you have experienced? (If you have not talked to the survivor about these terms, use the survivor's language.)

Pregnancy-Related Safety Planning Questions

Let's talk about safety concerns you have about your pregnancy.

- ▶ You have talked about your concerns when your partner is upset or angry. Has your partner ever tried to harm you during your pregnancy? What does he or she do? (i.e., abuse directed at her abdomen)
- ▶ Do you feel that your pregnancy is something that your partner uses to keep you under control? Can you describe what happened?
- ▶ Who can you count on to provide support during your pregnancy?

Birth Control Safety Planning Questions

We have talked about your partner manipulating/hiding or damaging/destroying your birth control.

- ▶ Do you have any options for putting your birth control in a safe place that your partner doesn't know about? (for example, in with feminine hygiene supplies)
- ▶ Would you like to know more about birth control options that can't be seen or felt by your partner, like the IUD or an implant? (Resources for birth control information: Birth Control Methods That Can be Used without a Partner's Knowledge poster (see Appendix H), Planned Parenthood at www.plannedparenthood.org/health-topics/birth-control-4211.htm, Bedsider at www.bedsider.org)
- ▶ Do you have access to money to pay for birth control? If not, we may be able to find financial resources to cover the cost or find coverage for prescriptions.
- ▶ You've told me that you are interested in forms of invisible birth control. Let's make a plan to get you access to birth control. I can go with you or help you make an appointment, or both.
- ▶ I can introduce you to ____ at the clinic. This person has worked with women who have come to our program, and is very understanding.

Parenting Safety Planning Questions

You have told me that you are worried that your partner will be a poor parent for your baby.

- ▶ Once the baby is born, there are legal options that could limit your partner's access to your baby, and options for financial benefits or support to help you.
- ▶ Would you like to know more about your options (i.e., custody, court-ordered parenting plans, court-ordered alcohol/drug evaluations, court-ordered batterers' treatment programs, supervised visitation, public benefits/economic services)?
- ▶ You said you are interested in breastfeeding, do you think your partner will be okay with you breastfeeding?
- ▶ I can give you a referral to talk to someone about options for feeding your baby (i.e., consult with trauma-informed lactation specialist, breast pump, formula, when and where you may feel comfortable nursing).

Safety Planning for Health Care and Family Planning Appointments

Let's talk about when and how to make an appointment at the clinic.

- ▶ We can expect that the clinic will want to confirm or remind you of your appointment or they may be calling with results of any tests. Let's call the clinic and make sure that they know they cannot call your house or cell phone, and can't send anything in the mail, or by email.
- ▶ Would you like to give the clinic alternative options for contact and receiving information, such as a friend's phone number and address, or our advocacy program office address or P.O. Box?
- ▶ You have shared with me that your partner has a pattern of stalking or has friends or family members watching you. We can plan how you will get to the clinic and home, if you would like.
- ▶ Some examples of plans that may help keep you safer are:
 - ▶ Driving in a different car
 - ▶ Not parking in the clinic lot
 - ▶ Creating an excuse for where you are spending your time
 - ▶ Paying cash instead of using a credit or debit card
 - ▶ Not keeping the paperwork on you after you are done
 - ▶ Planning for rest time after a procedure
 - ▶ Figuring out a safe place to keep medication

Appendix D: Emergency Contraception Information

Emergency Contraception Framing Statements

For those programs that choose to provide information about emergency contraception, we strongly recommend that advocates receive training on this issue from their local health department, family planning clinic, or Planned Parenthood.

This may not be a concern for you now, however it is information we offer to everyone who uses our services. Emergency contraception is available if:

- ▶ Your current birth control method is not effective/active.
- ▶ Your partner wanted to have sex, or pressured you to have sex and you didn't want to.
- ▶ You are worried that you may be pregnant (this question may be helpful for teens who if they don't know that you can't test for pregnancy right after sexual intercourse, for example).
- ▶ The person you are having sex with is not all that you hoped for.
- ▶ The person is not the one you want to spend the rest of your life with – not “the one” for you forever.
- ▶ You are not ready to be a parent.

Emergency Contraception Intake Questions

- ▶ Did you know that there is a birth control option called emergency contraception that works best within three days of sexual intercourse and can prevent pregnancy? It is taken in pill form and can be taken up to 5 days or 120 hours after unprotected sex. (Note: While emergency contraception—except Ella, available by prescription only—is most effective within the first three days after unprotected sex, it is still effective up to five days or 120 hours after unprotected sex.)
- ▶ Plan B One-Step is available on store shelves. There is no age restriction or prescription requirement to buy Plan B One-Step. You should know there are generic options of emergency contraception that are less expensive but not on store shelves. A pharmacist or healthcare provider may be able to provide Next Choice One Dose or another generic brand of emergency contraception. However, if you are under 17, you will need a prescription to purchase the generic options that are not on store shelves.

RESOURCES

- ▶ The Reproductive Health Access Project (<http://www.reproductiveaccess.org/resource/emergency-contraception-ec-right>) offers a patient information fact sheet on Emergency Contraception in English and Spanish.

Appendix E: The Good Cause Exception

Individuals who receive TANF (Temporary Assistance for Needy Families) are required to cooperate with the Division of Child Support (DCS). Often cooperating with DCS is unsafe for those experiencing domestic violence. The Good Cause exception exempts those experiencing domestic violence from having to cooperate with DCS. The Good Cause exception is approved by the Department of Social and Health Services (DSHS) if it is determined that pursuing paternity, or obtaining cash or medical support from the noncustodial parent could result in serious physical or emotional harm to the child or custodial parent/caretaker. This exception may also apply in instances of rape or incest, or when an adoption is taking place (WAC 388-14A-2045). If you think someone would benefit from the Good Cause exemption, assist them in contacting their case worker at the local welfare office. For detailed information about the process for obtaining the exception, see WSCADV's Get Money Get Safe site – www.getmoneygetsafe2.org.

If Good Cause is granted, the DSHS case worker will describe what kind of protection is available, and then it is up to parents to request what is best for their situation. If the situation improves or worsens, the parent can request a change in the level of protection at any time.

During the initial paternity interview at the Child Support Prosecutor's Office, the parent should always be informed about the Good Cause process and its exceptions. Parents or caregivers should be asked what they would like to have happen.

There are two levels of protection under WAC 388-14A-2060:

Level A: DCS **will not** pursue the establishment of paternity, establishment of a support order, collection of child support or medical insurance coverage from the Non-Custodial Parent (NCP) because any contact with the NCP poses a risk of serious harm to the child or individual. DCS closes the child support case, takes no actions on the child support case and the individual will not receive child support.

Level B: DCS will pursue the establishment of a support order and collect child and/or medical support without the adult or caregiver's cooperation, as long as such activity would not result in risk of serious harm to the child or adult. Although DCS cannot require the individual to cooperate, they may elect to cooperate if there is no risk of serious harm.

When good cause (Level A), is granted, it is not appropriate to proceed with the paternity case. In cases where Good Cause (Level B), is granted, the state can proceed to establish paternity, but only if the action can be done without causing harm to the adult/caregiver or child, or without requiring their participation in the process.

For example, “Generally, paternity establishment is not pursued in Level B cases because these proceedings usually take place in the county of residence of the child and require the cooperation and involvement of the child and custodial parent.”

<https://www.dshs.wa.gov/esa/social-services-manual/good-cause>
Scroll down to Parent Interview, No. 8, Level B.

DCS (Division of Child Support) - WAC 388-14A-2060; WAC 388-14A-2065 and WAC 388-14A-2070 – all the requirements around child support.

CSD (Community Services Division) - WAC 388-422-0010 – Do I have to cooperate with DCS? Requirements when someone is receiving TANF or Family Medical Benefits.

CSD (Community Services Division) - WAC 388-422-0020 – What if you are afraid that cooperating with DCS may be dangerous for you or the child in your care? (explains what Good Cause Exception is and the process for approval)

Specific information about how DSHS workers establish Good Cause is available in the Social Services Manual at <https://www.dshs.wa.gov/esa/social-services-manual/good-cause>

For questions about the Good Cause process, contact: Traci Underwood, Washington State Coalition Against Domestic Violence, at traci@wscadv.org or 206.389.2515, ext. 213 (v)

Appendix F: Washington State Resources

Enhance your referral list for survivors of intimate partner violence, and reproductive and sexual coercion.

- ▶ Washington State Attorney General, Washington Coalition of Sexual Assault Programs, & Washington State Coalition Against Domestic Violence - **Practice Guidelines for Working with Pregnant and Parenting Survivors: An Integrated Approach to Intimate Partner Violence and Reproductive & Sexual Coercion** – www.pregnantsurvivors.org
- ▶ **Washington State Department of Health, Local Health Jurisdictions**, to find services in your county, select your county from the map or text menu. <http://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions>
- ▶ **Planned Parenthood Federation of America**, www.plannedparenthood.org. You can find local health centers in Washington.
- ▶ **Washington Association of Community Migrant Health Centers** - find local clinics in Washington State www.wacmhc.org
- ▶ **Doula information**
 - ▶ **PALS Doulas** www.palsdoulas.org
 - ▶ **Open Arms Perinatal Services** www.openarmsps.org
- ▶ **Domestic Violence programs in Washington State** <http://wscadv.org/get-help-now/>
- ▶ **Sexual Assault programs in Washington State** www.wcsap.org/find-help
- ▶ Immigration resources – **Northwest Immigrant Rights Project** www.nwirp.org
- ▶ **Family Planning and Reproductive Health Clinics** <http://www.doh.wa.gov/YouandYourFamily/FamilyPlanning/Clinics.aspx>
- ▶ **First Steps** <http://www.hca.wa.gov/medicaid/firststeps/Pages/index.aspx>
 - ▶ “First Steps is a program that helps low-income pregnant women get the health and social services they may need,” including Maternity Support Services, infant case management, a variety of medical and dental services, and expedited alcohol and drug treatment, among other services.

- ▶ Washington Association of Sheriffs and Police Chiefs. (2009). **Manual for Law Enforcement Agencies: Stalking and Sexual Assault within the Context of Domestic Violence** http://www.waspc.org/assets/JbrsSavin/le_dv_training_manual_2009.pdf

- ▶ **WithinReach** www.withinreachwa.org
 - ▶ WithinReach is a Washington state nonprofit that connects individuals and families to health and food resources. They run three statewide hotlines and two resource websites, www.ParentHelp123.org and www.WashingTeenHelp.org, which is specifically for pregnant and parenting teens. They also sponsor a statewide Breastfeeding Coalition that offers assistance for nursing mothers.

- ▶ General (not state-specific) information on sexual assault dynamics and legal issues for all disciplines: **Judges Tell – What I Wish I Had Known Before I Presided in an Adult Victim Sexual Assault Case** <http://www.legalmomentum.org/resources/judges-tell-what-i-wish-i-had-known-i-presided-adult-victim-sexual-assault-case>

Appendix G: Birth Control Methods That Can Be Used Without A Partner's Knowledge

This document is also available as a PDF at www.pregnantsurvivors.org

Birth Control Methods

That Can Be Used Without a Partner's Knowledge

What is it?	How does it work?	How long is it effective?	Helpful hints	Risks of detection
Injection Depo-Provera ("The Shot")	Depo-Provera is a hormone shot that prevents an egg from being released.	3 Months	Once administered, there is no way to stop the effects of the shot.	Irregular bleeding is common. Periods may stop. This may be a less safe option if her partner closely monitors her menstrual cycles.
Emergency Contraception (EC) AKA: The Morning After Pill, Plan B, Next Choice	A single dose of hormones given by one or two pills within 120* hours of unprotected sex to prevent an egg from being released.	Single Dose <i>(must be taken after every instance of unprotected sex)</i>	Clients can get emergency contraception to keep on hand before unprotected sex occurs. EC is NOT an abortion; it works just like "regular" birth control pills. It prevents an egg from being released.	Clients can remove the pills from the packaging so they are easier to hide and partners will not know what they are.
Implant Nexplanon	A matchstick-sized tube of hormones inserted just under the skin of a woman's upper, inner arm to prevent an egg from being released.	3 Years	Unlike previous implantable methods (Norplant), it is generally invisible to the naked eye and scarring is rare.	The implant might be detected if touched. Irregular bleeding is common. Periods may stop. This may be a less safe option if her partner closely monitors her menstrual cycles. Many women bruise around the insertion site. The bruising may be noticeable for several days after insertion.
Intrauterine Device (IUD) ParaGard <i>(non-hormonal)</i>	A small T-shaped device inserted into the uterus to prevent pregnancy by changing the lining of the uterus so an egg cannot implant.	10 Years <i>(some data has shown effectiveness up to 12 years)</i>	This IUD contains copper. Periods may get slightly heavier. Period cramping may increase. ParaGard can be used for emergency contraception if inserted up to 7 days after unprotected sex.	The IUD has a string that hangs out of the cervical opening, which may be felt when fingers or a penis are in the vagina. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel the strings or pull the device out. If a woman's partner is monitoring her menstrual cycle, this is the least detectable birth control option because periods do not get lighter or stop. However, some spotting between periods is common at first.
Intrauterine Device (IUD) Mirena & Skyla <i>(hormonal)</i>	A small T-shaped device inserted into the uterus to prevent pregnancy by: <ul style="list-style-type: none"> making the lining of the uterus thin so an egg cannot implant thickening cervical mucus to prevent sperm from entering the uterus inhibiting sperm from reaching or fertilizing an egg stopping an egg from being released in some women 	Mirena: 5 Years <i>(some data has shown effectiveness up to 7 years)</i> Skyla: 3 Years	Hormonal IUDs have a very small amount of hormone that is released which can lessen cramping around the time of a period and make periods lighter. Some women may stop bleeding altogether. All IUDs can be used by women regardless of their pregnancy history or age, but Skyla was FDA-approved specifically for women who have never been pregnant and younger women.	The IUD has a string that hangs out of the cervical opening, which may be felt when fingers or a penis are in the vagina. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel the strings or pull the device out. Irregular bleeding is common, especially in the first six months. Periods will change and may stop. This may be a less safe option if her partner closely monitors her menstrual cycles.

*EC packaging may say that the pills should only be taken within 72 hours after unprotected sex and, if given the two-pill option, to take the pills 12 hours apart. Research has proven EC is effective up to 120 hours after unprotected intercourse (although efficacy decreases after 72 hours) and, if given two pills, it is more effective to take both pills together rather than 12 hours apart. (<http://ec.princeton.edu/info/ecmimp.html>)

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Portions of this resource have been adapted from Futures Without Violence's *Healthy Moms, Happy Babies* training curriculum www.FuturesWithoutViolence.org. We are indebted to Futures Without Violence for permission to adapt their materials and their assistance with this project.



Appendix H: Frequently Asked Questions About Making Over-the-Counter Medication Available in Domestic Violence and Sexual Assault Programs

FAQ

Frequently asked questions about making over-the-counter medication available in domestic violence (DV) and sexual assault (SA) programs

Q: Can our DV and dual advocacy programs make over-the-counter (nonprescription) medication*, pregnancy tests, and emergency contraception available to women and their children using our program services?**

*non-prescription

**non-prescription for 16 and under (as of June 10, 2013), available for purchase without age restrictions when manufacturing and labeling changes. Check with your local pharmacy.

A: Yes! The good news is that we can remove barriers and give women access to over the counter medication for themselves or their children in our programs.

Things to consider

Offering

When you **offer** a first aid kit to someone who has cut themselves, the adult chooses whether or not to use what you are offering. You are not ordering them to use a Band-Aid, just offering. By letting folk know that you have Tylenol, aspirin, children's cough syrup, pregnancy tests or emergency contraception available, you are providing information, not directing someone to use any of these items.

Dispensing

“Dispensing” has a particular legal implication and refers to prescription drugs.* Letting someone know that you have over-the-counter medication available if they feel the need for it is not the same as *dispensing* medication. The woman is choosing to take Tylenol or give her child cough syrup; it is her choice. DV and dual programs are neither prohibited from nor directed to make over-the-counter medication available to our program participants according to state codes (see WAC 388-61A-0560). Our WAC requires programs to have a secure way to store medications with immediate access to the program participant (see WAC 388-61A-0570).

**Drug dispensing: the preparation, packaging, labeling, record keeping, and transfer of a prescription drug to a patient or an intermediary, who is responsible for administration of the drug. --Mosby's Medical Dictionary, 8th edition (2009).*



Controlling

Survivor-centered, empowerment-oriented programs want to **avoid** controlling survivors' medications; that is why our WAC specifies that individuals must have secure storage and ready access to their medications. Survivors should be in control of their own and their children's medicine. But when we make it difficult for survivors to have immediate and timely access to over-the-counter medication that they may need, we are controlling their choices, and failing to offer a full range of options for responding to the abuse and making one's own choices. It is okay to expand a survivor's control and choices over her own and her children's health by safely making available over-the-counter medications – just as you would make available a Band-Aid, Ace bandage or ice for a wound. Increasing the ease with which a survivor can make choices about over-the-counter medications can impact her life beyond her interaction with your program. In particular, making emergency contraception available in a timely manner can give a survivor the chance to prevent an unintended pregnancy.

Q: What do some programs do?

A: Programs around the state have implemented many different and creative ways of meeting the medication and contraception needs of survivors.

Examples

Provide sample sizes of Tylenol, ibuprofen, aspirin or cough medicine.

Offer the larger-size item and ask for people to take what they need and return the item immediately.

Let program participants know that the programs have pregnancy tests and emergency contraception on site (don't wait until someone asks).

Give everyone an individual lock box for storage of over-the-counter medication, and prescription medication.



Q: What are the relevant WACS?

A: WAC 388-61A-0560

What first aid supplies must I approve? “You must keep first-aid supplies on hand and accessible to clients residing in shelter for immediate use. First-aid supplies must include at a minimum the following: First-aid instruction booklet, band-aids, sterile gauze, adhesive tape, antibiotic ointment single use packets, antiseptic wipe single use packets, hydrocortisone ointment single use packets, roller bandage, thermometer (nonmercury/nonglass), and nonlatex gloves. In instances where an adult or child has ingested a potentially poisonous chemical or substance, you must call the Washington Poison Center for further instruction.” [Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0560, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0570

What are the requirements for storing medications? “(1) Clients residing in shelter must be provided with a means to safely and securely store, and have direct and immediate access to, their medications such as individual lock boxes, lockers with a key or combination lock, or a similar type of secure storage.(2) All medications, including pet medications and herbal remedies, must be stored in a way that is inaccessible to children.” [Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0570, filed 10/27/10, effective 11/27/10.]



Appendix I: Additional Tools and Resources from the Coalitions

These are resources developed by the Washington State Coalition Against Domestic Violence (WSCADV) www.wscadv.org and the Washington Coalition of Sexual Assault Programs (WCSAP) www.wcsap.org. Please check the Coalitions' websites for additional resources and training opportunities, under Training and Events.

WEBINARS

Emergency contraception – it's over the counter. Why not in your desk drawer? - recorded webinar from WSCADV and WCSAP

<http://www.wcsap.org/emergency-contraception-recorded-webinar>

What Do Birth Plans and Stealth Birth Control Have to Do With Advocacy? Innovative Strategies for Addressing the Reproductive Health Needs of Domestic Violence and Sexual Assault Survivors – recorded webinar from WCSAP and WSCADV, <http://www.wcsap.org/Innovative-strategies-addressing-reproductive-health-needs>

Sexual Assault and Coercion in Teen Relationships – recorded webinar from WCSAP, <http://www.wcsap.org/sexual-assault-and-coercion-teen-relationships>

BOOKLETS

These are available for free download from the WCSAP website:

Creating Trauma-Informed Services: A Guide for Sexual Assault Programs and Their System Partners

<http://www.wcsap.org/creating-trauma-informed-services-guide-sexual-assault-programs-and-their-system-partners>

Reproductive Health Advocacy Strategies for Sexual Assault Survivors

<http://www.wcsap.org/reproductive-health-advocacy-strategies-sexual-assault-survivors>

REPORTS

WSCADV Domestic Violence Fatality Review Project

<http://dvfatalityreview.org>

TRAINING ACTIVITY

In Their Shoes: Teens and Dating Violence – interactive training tool from WSCADV for adults and in a classroom version for teens

<http://wscadv2.org/resourcespublications.cfm?aid=caed6100-c29b-57e0-8bc7dd70f6ff931d>

POSTERS AND BOOKMARKS

Available for free download in six languages from WCSAP at <http://www.wcsap.org/ipsv-resources-publications>.

In Any Relationship... Posters

In Any Relationship ... Bookmarks

PRACTICE GUIDELINES

Washington State Attorney General, Washington Coalition of Sexual Assault Programs, & Washington State Coalition Against Domestic Violence - **Practice Guidelines for Working with Pregnant and Parenting Survivors: An Integrated Approach to Intimate Partner Violence and Reproductive & Sexual Coercion** – www.pregnantsurvivors.org