ADVANCING HEALTH-CARE PRACTICE

Exploring the Links Between Woman Abuse, Substance Use, and Pregnancy/early Parenting

- **Lynda Dechief, M.Sc.**
- Coordinator, Maxxine Wright Place Project for High Risk Pregnant & Early Parenting Women (Atira Women's Resource Society)
- Research Associate, Woman Abuse Response Program

maxxwright@atira.bc.ca

- **Jill Cory, B.A.**
- Coordinator, Woman Abuse Response Program (BC Women's Hospital)
- Coordinator, British Columbia Women's Health Network

jcory@cw.bc.ca

Web-based workshop

- Created by Atira Women's Resource Society and BC Women's Woman Abuse Response Program, in partnership with Fraser Health and Kwantlen University College Nursing Program
- Funded by the BC Ministry of Health Nursing Directorate
- Located at:

www.atira.bc.ca/AdvancingHealthCareWorkshop

5 Modules

MODULE 1:	A New Perspective of Abuse in the Workplace
MODULE 2:	Understanding Woman Abuse and Women's Health
MODULE 3:	Understanding Women's Use of Substances
MODULE 4:	Pregnancy & Early Parenting Under Duress
MODULE 5:	Best Practice: Linking Women-Centred Care and Harm Reduction

Goals of the workshop

- To further our understanding of the complex relationships between gender-based violence, substance use, mental health, pregnancy, parenting, and race/culture.
- To give nurses and allied health and social service providers tools in supporting women facing these issues that women themselves tell us are helpful.
- To recognize that we need to critically analyze our own values, institutions and routine practices in order to provide the best care possible.

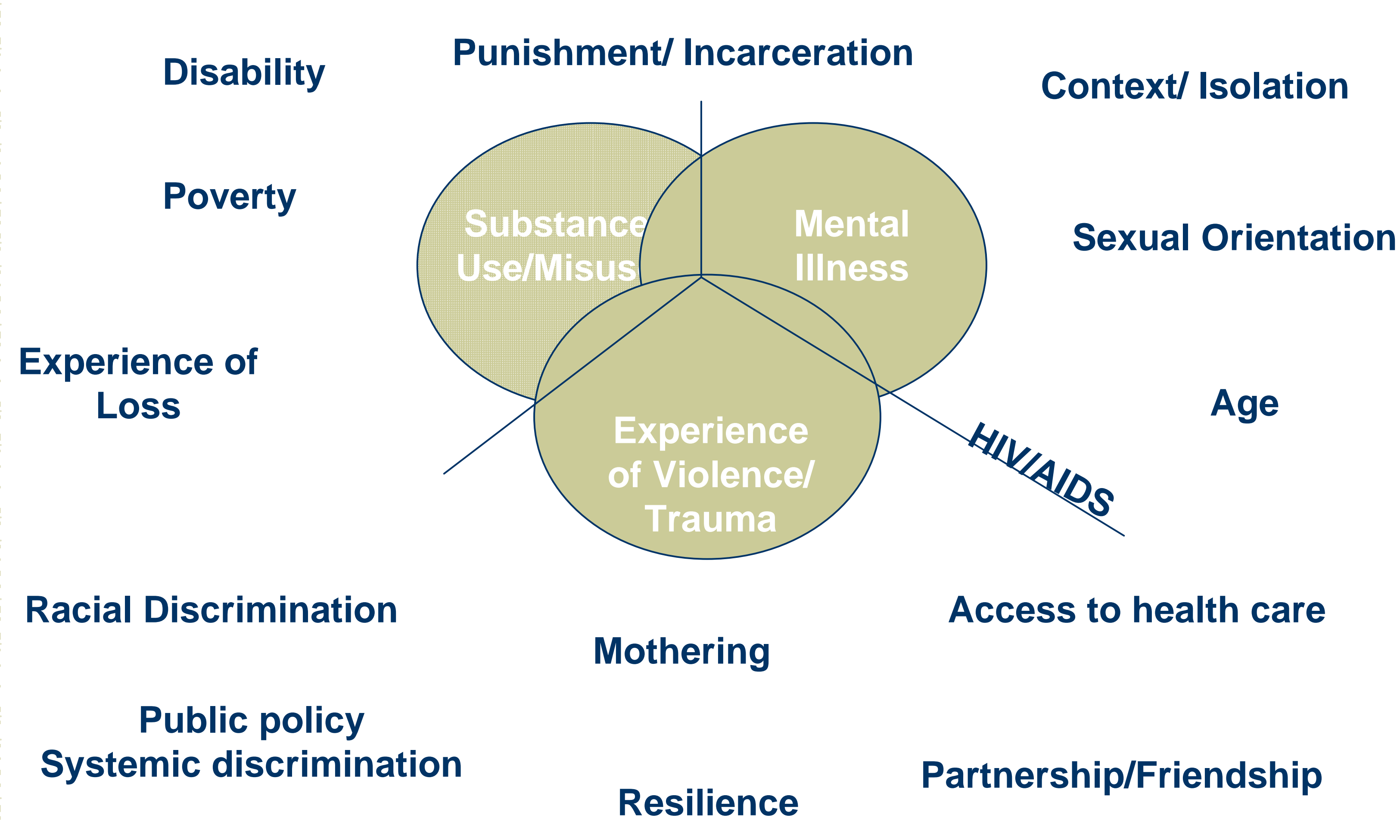
Study of birth mothers of 160 children with fetal alcohol syndrome

- 40 could not be contacted due to confidentiality issues
- 40 had died or had disappeared and were presumed dead
- Of the 80 interviewed:
  - 80% had major mental illness
  - 100% had been seriously sexually, physically or emotionally abused
  - 80% lived with men who did not want them to stop drinking
  - 60% had phobias – most common was agoraphobia – so they were reluctant to leave home and go for help

What are the links between high risk issues?

1. One in ten women in the general population are currently experiencing abuse. One in four / six / eight women who use substances are currently experiencing abuse (Miller, 2001).
2. As many as three / six / eight in ten people who use substances also suffer from mental illness. Depression and anxiety disorders usually precede / result from the substance use (Volkow, 2000).
3. More than 35% / 50% / 70% of those with Post-Traumatic Stress Disorder are women. (And those with PTSD are 3-5 times more likely to use alcohol or drugs. Kessler, 1995)

Intersections - A view of the complexity (Poole, 2004)



Understanding Women’s Lives

“If the women perceive that a service provider does not have a good understanding of the context of their lives, then they are less likely to act on suggestions or advice and more likely to perceive the interaction as negative”

(Best Start, 2001)

MODULE 1: A New Perspective of Abuse in the Workplace

CORE VALUE:

- In order to promote respectful, empowering interactions with patients, health care settings must strive to create such interactions between colleagues and foster organizational values of equality and respect.

MODULE 1: A New Perspective of Abuse in the Workplace

This module is intended to:

- provide an opportunity to explore abuse in the work environment and
- gain a new perspective about abuse in the workplace.

Topics

- Abuse in the Workplace
- Standards of Practice
- Cycle of Abuse
- Tactics/Experiences of Abuse
- Barriers to Reporting
- Hierarchies in Health-care
- Power and Control Wheel
- First Steps in Addressing Abuse

Workplace Abuse

Abuse defined as:

- "some form of mistreatment, spoken or unspoken, that leaves its victim feeling personally or professionally attacked, devalued or humiliated. It is communication through words, tone or manner that disparages, intimidates, patronizes, threatens, accuses or is disrespectful toward another."

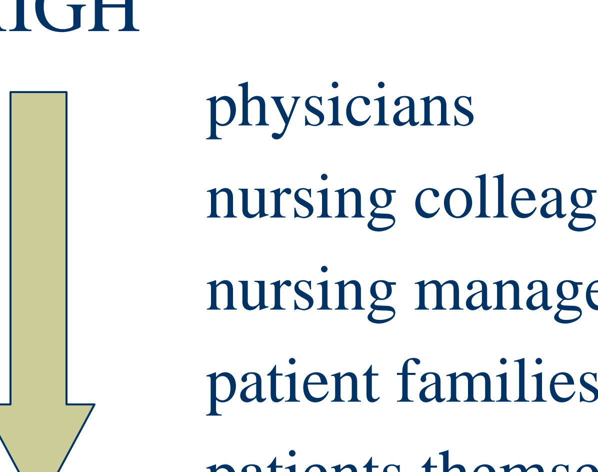
(Sofield & Araujo, 1999).

Workplace Abuse

- 90% of nurses experienced verbal abuse (Cox, 1987).
- Average of 5 incidents per month (Cox, 1987).
- Physicians are the most common perpetrators of verbal abuse against nurses (Sofield & Araujo, 1999; Cox, 1987; Rosenstein, 2002).

Workplace Abuse

Nurses' experiences of abuse come from:



physicians
nursing colleagues
nursing management
patient families
patients themselves.

(Cox, 1987; Araujo & Sofield, 1999; Rosenstein, 2002)

Linking Experiences of Abuse

- In three practice sites (public health, hospital, and private practice), 31% of nurses reported abuse of themselves or family members. (Moore, Zaccaro, & Parsons, 1998)
- At BC Women's Hospital, 37% of nurses reported experiencing abuse in their intimate relationships. (Janssen, Basso & Constanzo, 1998)
- The Women Physicians Health Study found 3.7% of female physicians reported having experienced abuse in their intimate relationships. (Doyle et al, 1999)

MODULE 2: Understanding Woman Abuse and Women's Health

This module is intended to:

- support nurses and allied health care professionals to gain a deeper understanding of how living in an abusive relationship can impact a woman's health and health care.

Topics

- Cycle of Violence
- Why Women Stay
- Power and Control
- Health Impacts of Violence Against Women
- Barriers to Accessing Health Care
- Impact of Health Care Practices
- Using Children

Violence against women

Consider that:

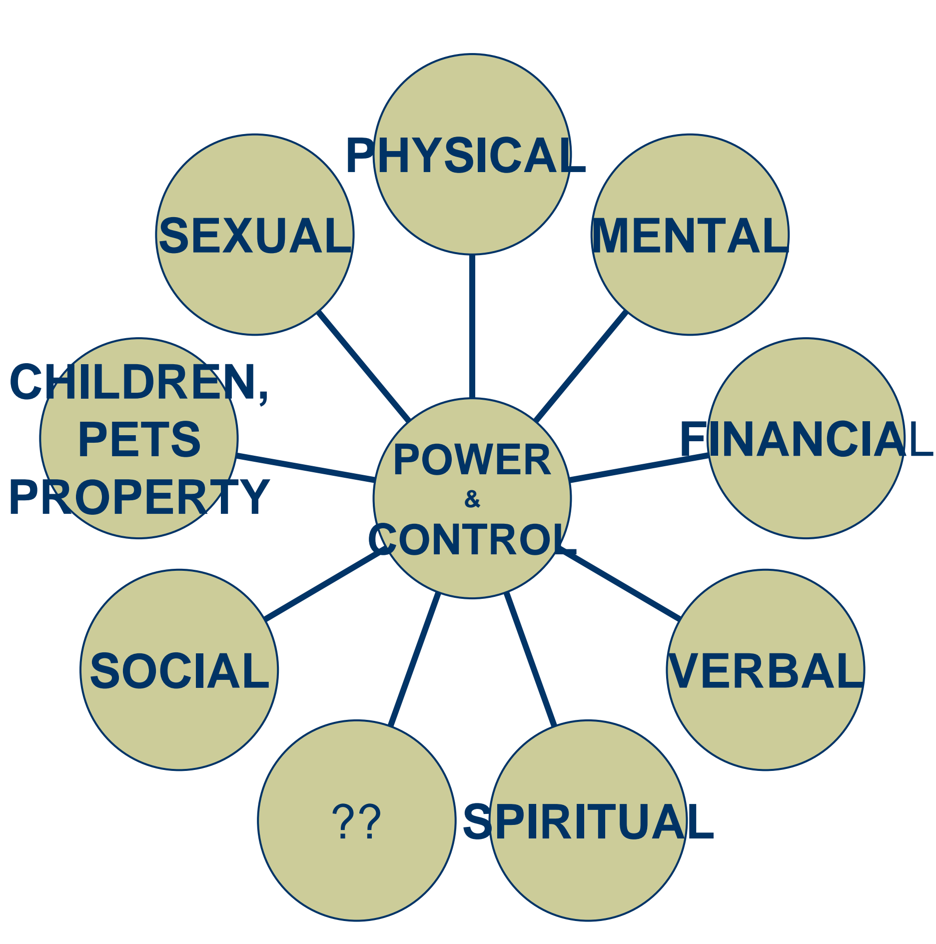
- 1 in ____ women will experience physical or sexual assault by a partner at some point in their adult lives (Statistics Canada, 1993)
- 1 in ____ women in Canada are experiencing abuse right now (Ratner, 1999)

What is violence against women? Myths and Realities

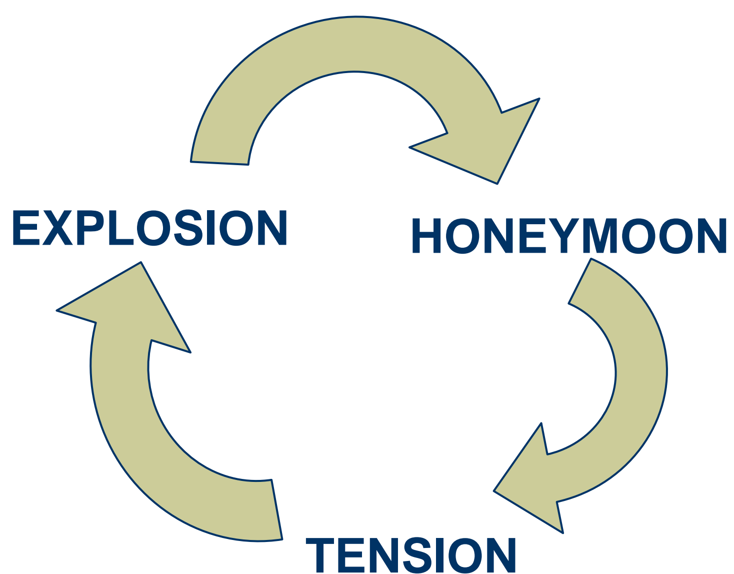
- Abuse is limited to physical violence
- Men are not in control of their abusive behaviour
- Impact of abuse is defined by the woman
- Men initially conceal their abusiveness
- Men are behaving in socially sanctioned ways

- All aspects of the relationship are determined by the abuse
- Abuse is patterned and intentional
- Some women are attracted to abusive men
- Both partners are responsible for problem
- Tactics are used intentionally for control

A pattern of control



The Cycle of Abuse



The Cycle of Abuse: EXPLOSION

MEN'S TACTICS

- threatening body language
- physically constrains or restricts freedom
- silent treatment
- physical or sexual assault
- name calling, swearing, yelling
- prevents partner from sleeping
- threatens to take or harm kids
- threatens to kill her or her family
- threatens suicide

WOMEN'S EXPERIENCES

- trying to protect herself and the children
- physical injuries, poor health
- acquiesce, give in
- feels degraded, terrified
- feels trapped
- yell back, fight back
- feels responsible
- Loss of human rights and dignity
- death

The Cycle of Abuse: HONEYMOON

- MEN'S TACTICS
  - apologizes
  - asks forgiveness
  - attentive
  - helps with household chores
  - promises to change, to get help
  - buys gifts
  - spends time with family
  - acts supportive

- WOMEN'S EXPERIENCES
  - feels hopeful, relieved
  - exhausted, feels numb
  - feels sceptical, distrustful, anxious
  - feels scared, fearful, confused
  - respite, time to heal
  - doesn't think promises are genuine
  - feels reconnected with partner, enjoys contribution

The Cycle of Abuse: TENSION

- MEN'S TACTICS
  - uses insults, threats, sarcasm to intimidate
  - uses jealousy and accusations to control
  - finds fault in everything/anything
  - erratic mood changes
  - emotionally distant
  - angry
  - silent treatment
  - prevents her from seeing family or friends
- WOMEN'S EXPERIENCES
  - withdraws, isolated by partner
  - feel anxious, depressed, hopeless
  - tries hard to accommodate
  - feel like running away
  - feel trapped & like a fool for staying
  - afraid of doing wrong thing
  - walking on eggshells
  - trying hard to avoid explosion

IMPACTS OF ABUSE ON WOMEN'S HEALTH

"What appears to be a constellation of symptoms or disorders may reflect a normal response to trauma and the social realities of continued isolation and danger".

(Warshaw, 1997)

BARRIERS TO CARE FOR WOMEN

Medical Model

"The pressure to make rapid assessments, diagnosis and treatment recommendations often pushes clinicians into a mode of taking charge and maintaining control of clinical encounters".

(Warshaw, 1997)

Mitigating harms of abuse

"In relationships where autonomy and decision making are taken away, feeling free to makes choices without risking retaliation is crucial to regaining a sense of control"

(Warshaw, 1997)

Women-Centred Care

"For a woman who has been abused, experiencing equality, mutuality and respect are essential to the process of healing"

(Warshaw, 1997)

MODULE 3: Understanding Women's Use of Substances

This module is intended to:

- Support nurses and allied health care professionals to gain a deeper understanding of why women may use substances and how it can impact her health and health-care.

Topics

- Links between 'high risk' issues
- Why Women Use Substances
- Barriers to Treatment
- Cycle of Dependence
- Health Impacts
- Resources in Your Community

Why do women use drugs or alcohol?

- Forced to by a partner
- To appease her abuser
- To cope with the abuse, or other stresses
- Way to feel in control, when socially controlled
- To make sex easier
- Pain relief

Why do women use drugs or alcohol?

- To lose weight
- To control withdrawal symptoms
- For fun
- To be social
- To be accepted
- Experimental
- Out of habit
- Prescribed by a doctor

POWER AND CONTROL

USING THREATS AND PSYCHOLOGICAL ABUSE:
Making and/or carrying out threats to do something to hurt her. Instilling fear. Using intimidation, harassment, destruction of pets and property. Making her drop charges. Making her do illegal things. *Threatening to hurt her if she uses/ does not use drugs.*

USING EMOTIONAL ABUSE:
Making her feel bad about herself, calling her names, making her think she's crazy, playing mind games, humiliating her, *putting her down and making her feel guilty for past drug use.*

USING PHYSICAL ABUSE:
Inflicting or attempting to inflict physical injury by pushing, slapping, beating, choking, stabbing, shooting. *Physically abusing her for getting high/not getting high.*

USING ISOLATION:
Controlling what she does, who she sees and talks to, what she reads, where she goes. Limiting her outside involvement. Keeping her away from people supportive of her recovery. Preventing her from attending drug treatment and NA/AA meetings.

MINIMIZING, DENYING, AND BLAMING:
Making light of the abuse and not taking her concerns seriously. Saying the abuse didn't happen. Shifting responsibility for abusive behavior. *Saying she caused the abuse with her drug use.*

USING SEXUAL ABUSE:
Coercing or attempting to coerce her to do sexual things against her wishes. Marital or acquaintance rape. Physically attacking the sexual parts of her body. Treating her like a sex object. *Forcing her to prostitute for drugs or drug money.*

ENCOURAGING DRUG DEPENDENCE:
Introducing her to drugs, buying drugs for her, encouraging drug use and drug dependence.

USING ECONOMIC ABUSE:
Making or attempting to make her financially dependent. Preventing her from getting or keeping a job. Making her ask for money. Taking her money, welfare checks, pay checks. *Forcing her to sell drugs.*

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training · consulting · advocacy
7800 Shoal Creek, Ste 120-N · Austin, Texas 78757
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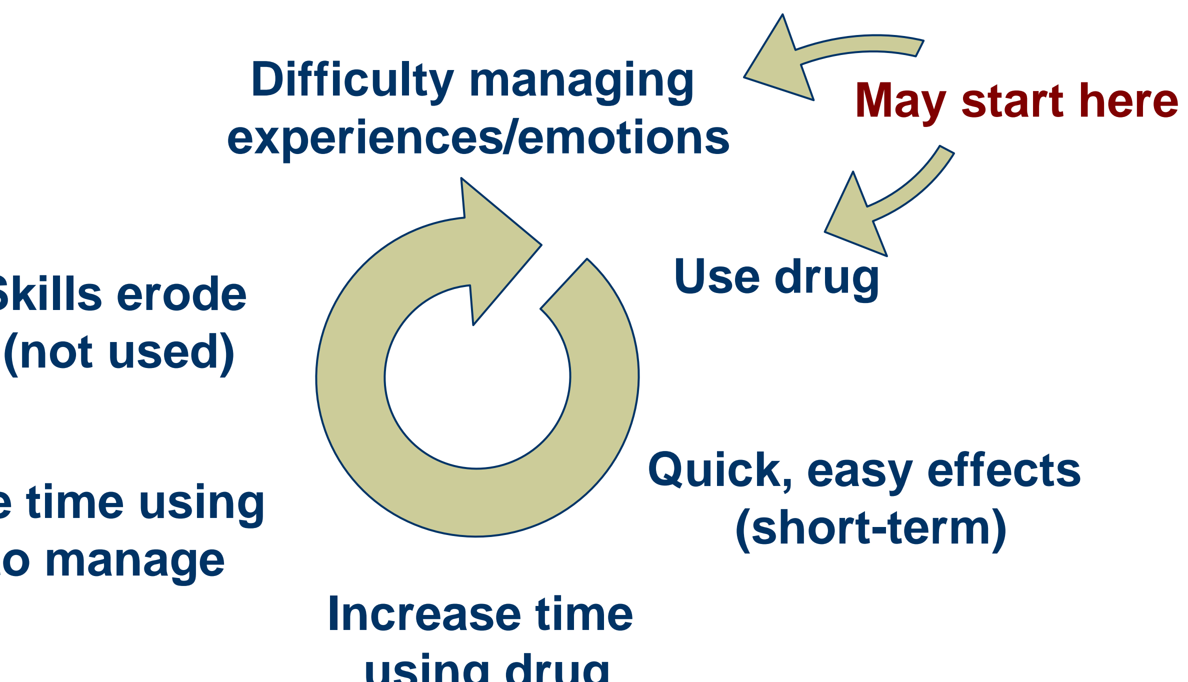
The cycle of dependence



Linking Women's Circumstances

"To substantially reduce the incidence of alcoholism and drug abuse in women of childbearing age ... social changes are needed in areas of financial supports, housing, health care, employment, child care, children's services, family supports, legal rights, and sexual division of labour in the family"

(Finklestein, 1994)

Barriers to Treatment for Substance-Using Mothers

- Shame (66%)
- Fear of losing children (62%)
- Fear of prejudicial treatment on basis of mother hood status (60%)
- Depression and low self esteem (60%)

More Barriers to Treatment for Substance-Using Mothers

- Belief they could handle the problem without treatment (55%)
- Lack of information about what treatment was available (55%)
- Waiting lists for treatment services (53%)

(Poole & Isaac, 2001)

Women-Centred Care

"The approach you take is one of the strongest indicators of whether a woman will change. It is just as important as the woman's personal characteristics and behaviour"

- The Smart Guide: Motivational Approaches Within the Stages of Change for Pregnant Women Who Use Alcohol (2002)

The SMART Guide

- Have I been impacted personally by the use of alcohol or other drugs?
- If I have been impacted, does this affect my ability to work with women who are pregnant, or have children, and who use drugs or alcohol?
- Do I have access to accurate, research- and evidence-based information about the effects of substance use on women and their children?

The SMART Guide

- Am I able to remain non-judgmental, empathic, respectful, and supportive when I encounter a pregnant woman, or woman with a young baby, who uses drugs or alcohol?
- Am I able to adopt a holistic perspective to assist a woman to improve her health?

The SMART Guide

- Can I adopt a harm reduction approach - in other words, can I provide her with assistance to reduce the harms associated with substance use rather than focusing only on abstinence or quitting substance use?
  - Can I overcome my personal beliefs about a woman's need to change her substance use? Can I support her self-determination and plans to change in a non-coercive and caring fashion?

The SMART Guide

- Can I stay hopeful while finding ways to encourage hope in a woman who is pregnant or has a young baby and is using substances?

MODULE 4: Pregnancy & Early Parenting Under Duress

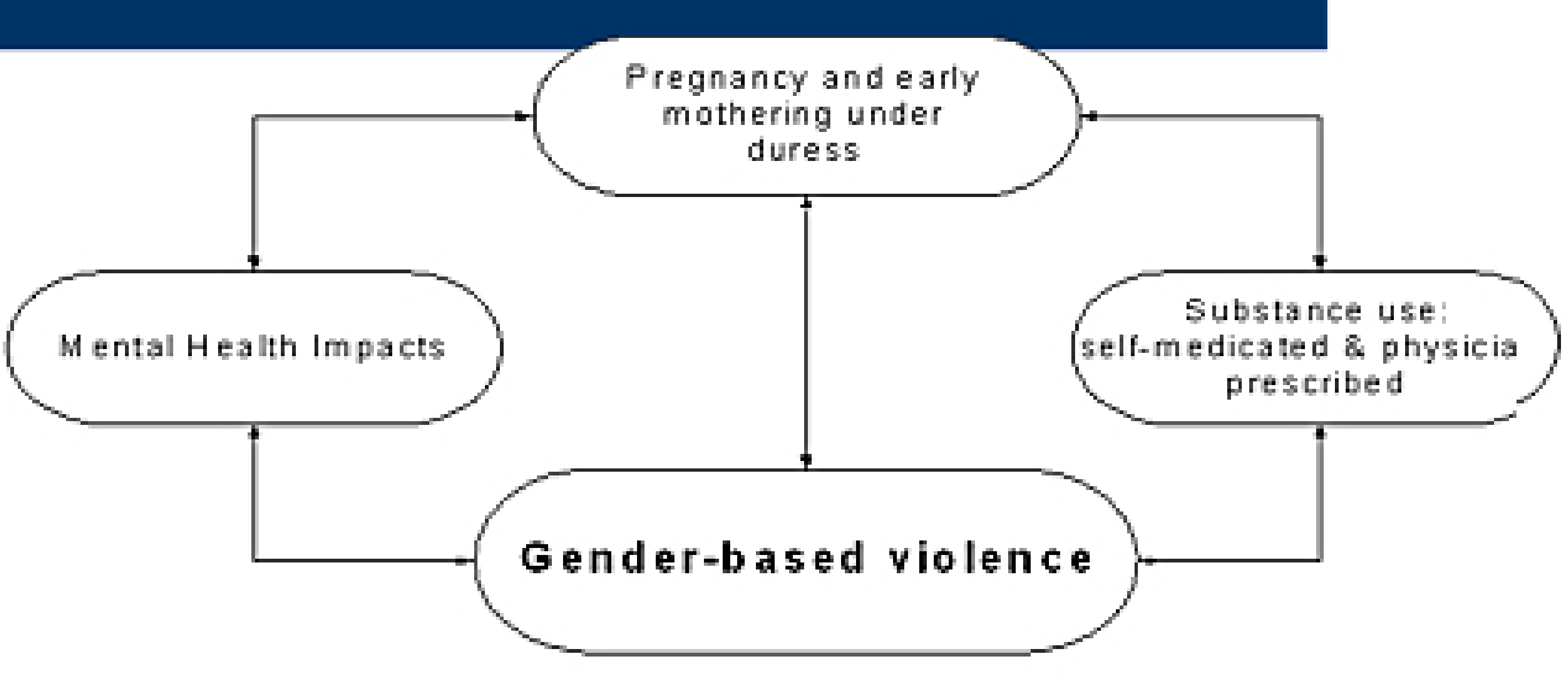
This module is intended to:

- support nurses and allied health care professionals to gain a deeper understanding of the unique challenges facing a woman who is pregnant or has a baby/young child and is struggling with substance use and/or violence/abuse in her relationship.

Topics

- 'High Risk' Issues
- Stereotypes of Mothering
- Barriers to Treatment & Support
- Harms & Helps
- Making Changes

Gender-based violence, substance use and mental health



Violence and Women's Health
BC Women's Hospital
Woman Abuse Response Program

Barriers to care for women with mental health issues

- Abused women may be judged as mentally ill, rather than traumatized
- Women with mental health diagnoses are often denied access to transition houses
- Women may be prescribed medications to address mental health issues, to which they can become addicted

Mothering Under Duress

(Greaves et al., 2002)

Mental illness	Woman abuse	Substance use
⟵		⟶
Out of woman’s control	Somewhat within her control	Deliberate
System failing	Limited system failure	Not system's fault

The ‘Perfect’ Mother

- Always perky
- Never frustrated
- Makes healthy lunches for her kids every day
- Is a good mother and wife
- Fit and attractive – always has perfect hair
- Has polite and well-behaved children
- Involved in her kids' schools and all their activities
- Never complains
- Has a clean house
- Buys her children everything they need, but doesn't 'spoil' them
- Might work, but still does all of the above

A 'Bad' Mother

- "Crack mom"
- Addicted to the abuse or masochistic – or why wouldn't she just leave?
- That's just the way her culture is
- Crazy
- Incapable
- Bad person
- Unfit to parent
- Victim
- "Junkie mother"
- Selfish
- Child abuser
- Sexually promiscuous
- Irresponsible
- Stupid to get pregnant

The Capable Mother

"Aside from the unrealistic demands of the traditional mother discourse and the selfish irresponsibility of the junkie mother discourse exists another discourse that is more supporting…I have called that the discourse of the **capable** mother"

(Lyons, 2002)

Top supports reported by pregnant women who use alcohol

- Supportive professionals
- Supportive family members
- Supportive friends/recovery group members
- Children as motivators to get help
- Health problems as motivators

(Poole & Isaac, 2001)

Positive health-care experiences of mothers in abusive relationships

- CARE – Feeling cared about, like a human being, that people understand her life
- CONTROL – Being asked open-ended questions, having a say in decisions, and how her information is shared
- CONNECTION – Feeling she can come back, having information about other resources with no pressure to access them

(Dechief, 2003)

MODULE 5: Best Practice: Linking Women-Centred Care and Harm Reduction

This module is intended to:

- support nurses and allied health care professionals to gain a deeper understanding of how women-centred care and harm reduction can improve women’s safety and health and reduce the risks that women face,
- reflect upon how to incorporate these principles in their own health settings

Topics

- Supporting Change
- Women-Centred Care & Harm Reduction
- Making the Links
- Medical Support & Advocacy Wheel
- Putting it All into Practice

Women-Centred Care Principles

Women-Centred Practice

- Put **safety** first
- Focus on **empowerment**
- Minimize health system **risks**
- Recognize **diversity** and **complexity** of women's lives
- **Respect** her **choices**
- **Believe** her

Women-Centred Practice

- Be **honest**
- Be an **advocate**
- Support her **decisions**
- Maintain **confidentiality**
- Obtain **consent**
- Partner with **community** support services

Harm Reduction

- A pragmatic and compassionate public health approach
- Shifts focus away from drug use to reduction of potential harmful consequences of substance use, and an increase in protective measures
- Not about what is morally right or wrong, but rather what is harmful or helpful

Harm Reduction

- Provides services without punishing people with stigmatic labels or presenting roadblocks or hoops to jump through to obtain services
- Provides information, education and resources

Harm Reduction

- Practical, client-centred, non-coercive and non-judgmental
- Builds on individual's existing capacities, strengths and practices
- Respects self-determination

Harm Reduction Principles

Harm Reduction Practice

- **Choice** in what is happening to them, and assistance in seeing and making choices
- **Respect** and a sense of their basic **dignity** as human beings wherever they are in the using/recovery process

Harm Reduction Practice

- **Absence of judgment or shaming** about their behaviour
- **Understanding** that they are doing the very best they can at the time
- **Interest** and **support** in what they are trying to or would like to accomplish, and our support in accomplishing that

(Addiction Research Foundation, 1996/7)

Need for integrated services

- Avoid single focus services
- Address issues in the context of women's lives, rather than from a purely diagnostic framework
- Work in partnership across systems to address women's safety by acknowledging the impact of violence on mental health, physical health and the use of substances

Traditional vs. Integrated Models

- Blaming the woman
- Unrealistic expectations of change
- Problematizing the woman
- Focus on individual deficits
- Using negative stereotypes
- Seeing professionals as the expert
- Not considering safety
- Professional-driven services
- Making women's and children's needs competing

- Safety and harm reduction are central
- Support
- Social, not individual, problem
- Strength-based
- Empowerment
- Peer support model
- Women viewed as experts
- Link between violence and substance use.
- Health issues addressed within the life context
- Coordination and collaboration between systems

HEALTH-CARE RESPONSES

that Empower Women Impacted by Relationship Violence and/or Substance Use

INCREASING SAFETY

HEALTH CARE RESPONSES

PRIORITIZING WOMEN'S SAFETY
Putting safety first. Asking about women's fears/concerns. Providing an emotionally and physically safe environment. Maintaining privacy and confidentiality.

REDUCING BARRIERS TO ACCESS
Understanding what it took for her to get to health-care today. Strategizing with her to facilitate her access to care. Being flexible wherever possible.

BUILDING TRUSTING RELATIONSHIPS
Focusing on relationship, not outcomes. Listening to women. Asking open-ended questions. Not asking 'screening' questions about relationship violence or substance use. Looking women in the eye. Being honest. Providing unconditional regard for her strengths, ingenuity and survival.

SUPPORTING DECISIONS
Sharing your health expertise. Recognizing she is the expert on her on own life. Believing and being guided by her experience. Respecting her right to make decisions in her own life, when she is ready. Getting over our own need to prescribe solutions.

MAKING THE LINKS
Recognizing the complexity of women's circumstances and choices. Understand the role of gender inequality and racism, as well as the links between violence, substance use and mental health. Addressing health issues. Working to reduce harm.

PROVIDING INFORMATION
Giving non-judgmental and accurate information about the health impacts of abuse/violence and substance use on women and infants/children. Avoiding scare tactics. Admitting when you don't know.

FOCUSING ON NEEDS OF WOMEN AND CHILDREN
Linking women's and children's needs. Supporting women in supporting their children. Recognizing her autonomy and roles separate from being a mother.

CONNECTING WITH RESOURCES
Sharing accurate and detailed information about community resources with women without pressuring her to access them. Developing relationships with shelters, community programs and advocates. Understanding the importance of your professional role within a continuum of support.

REDUCING HARM

HEALTH-CARE RESPONSES

that Empower Women Impacted by Relationship Violence and/or Substance Use