**Clinical Chats Official Podcast Transcript**

**Title:** Addressing Pregnancy-Associated Death: IPV and Homicide

**Speaker:** Karen Trister Grace, PHD, MSN, CNM

**Duration:** 00:28:58

**Katherine Atcheson (**[**00:05**](https://www.rev.com/transcript-editor/shared/L77bAKgmgEo50qBlyZdTBIexWF2uJsb1Kc0JadkCCU9zhyNTwjK_VN3-s5zXSvCl7og2l8JJZefH9kg79HKkTUH8KH0?loadFrom=DocumentDeeplink&ts=5.1)**):**

Hello and welcome to Clinical Chats, a podcast for sexual and reproductive health professionals. Clinical Chats, formerly known as the Family Planning Files, is a program from the Clinical Training Center for Sexual and Reproductive Health, or CTCSRH, formerly known as the National Clinical Training Center for Family Planning, or NCTCFP, and is funded by the Office of Population Affairs, in order to enhance the knowledge of Title X clinicians and other staff. In today's podcast, part of a multi-episode series on the role of Title X clinicians in preventing pregnancy associated death in the US, we'll be discussing how intimate partner violence contributes to pregnancy associated death rates, and how Title X clinicians can address IPV, or intimate partner violence, in their practices. Particularly for patients who may become pregnant or postpartum.

**Katherine Atcheson (**[**00:58**](https://www.rev.com/transcript-editor/shared/8f94gKofGVLd_3X8wJhQbx7f1ImljanElw5yAuq5eLnHUSuKbYlTjmmIboeq68unWjrvWhAC2gFcXTfcRFTabRE5Lx8?loadFrom=DocumentDeeplink&ts=58.5)**):**

Our guest today is Karen Trister Grace PhD, MSN, CNM. Dr. Grace is an assistant professor at the George Mason University School of Nursing, where her research focuses on reproductive coercion, intimate partner violence, and health equity. In addition to her academic work, Dr. Grace has been a practicing midwife for over two decades, and currently sees patients at Mary's Center, a nonprofit FQHC with locations in Washington, D.C. and Maryland. She received her doctorate from Johns Hopkins School of Nursing, and completed a postdoctoral fellowship at the Bloomberg School of Public Health. Dr. Grace is also a member of the Maryland Maternal Mortality Review Team. Welcome to the podcast, Dr. Grace, we're so excited to speak with you today.

**Karen Trister Grace (**[**01:48**](https://www.rev.com/transcript-editor/shared/Cx0LEGLdgd51eJ-zq_bHYt6iWgyMqHgVcKuyeSCCq4ejV2dyYT9y7mqZ9cDIvyt6gvL9aspb3RVkcAbQuyfsBzlVh4g?loadFrom=DocumentDeeplink&ts=108.51)**):**

Thank you so much for having me.

**Katherine Atcheson (**[**01:50**](https://www.rev.com/transcript-editor/shared/yszhf3tfx04y4U2csvxH3rmL4cdGHuc8RaoYsxWxLnU6z0Bgh-vA2NO0AKrT-TWNbhiv1-K3cNl9_SsV6jvjcuclKj0?loadFrom=DocumentDeeplink&ts=110.16)**):**

So, to begin with, for our listeners, how common is pregnancy associated homicide as a cause of maternal death in the US, especially compared to other causes of pregnancy associated death?

**Karen Trister Grace (**[**02:04**](https://www.rev.com/transcript-editor/shared/79lxQQx46fnendt5AfKYdYI3pgPDJLlcKVcZrLAwaVmOVz2lVfVP4O1VA_oO0Zqsd5lo-aM5Ajtk2C0zyftPw_aTIT4?loadFrom=DocumentDeeplink&ts=124.83)**):**

Yeah. So, the most recent data that I've seen reported comes from Wallace and colleagues, a former guest on your show, that was an excellent episode of this podcast, by the way. So, Wallis and colleagues looked at data from 2018 and 2019, and they showed that the risk of homicide in the perinatal period, so up to one year postpartum, was 3.62 per 100,000 live births, which is significantly higher, 16% higher, than the rate of homicide among women outside of the perinatal period. And when we look just at the period of pregnancy and up to six weeks postpartum, maternal mortality rate from homicide is higher than the rate due to hemorrhage, hypertensive disorders, and the rate due to sepsis, which those are the leading obstetric causes of death during that period.

**Karen Trister Grace (**[**02:59**](https://www.rev.com/transcript-editor/shared/ECPlzzwMUKpKlDADCQ_D7w0wDhke3D1NliS3pRmhLnuX2HCb9iPr5lanzY8VnrOWPUE-ZO40zYgLwqbbc6vozU6aMB8?loadFrom=DocumentDeeplink&ts=179.49)**):**

So, this study didn't specifically look at who was perpetrating the homicide, whether it was IPV, or street violence, or home invasion, et cetera, but they did find that about two thirds of the homicides occurred in the home. So, some indication there that these might be related to IPV. One estimate using older data that I saw found that of pregnancy associated homicides close to half were related to IPV.

**Katherine Atcheson (**[**03:29**](https://www.rev.com/transcript-editor/shared/qvGAjXdI9OloKtXRoaixn9KdG8EY4NwYvZZrJ1z73oPyy9K7fIJadAzoDy_wAcgzGqKxXN69wuWd2ut0oHeReE4Tvpo?loadFrom=DocumentDeeplink&ts=209.61)**):**

And what do we know about the incidents of intimate partner violence in and around that pregnancy period? So, the whole of pregnancy and that full year postpartum?

**Karen Trister Grace (**[**03:41**](https://www.rev.com/transcript-editor/shared/y54RHrK7Xuv679x_V8w6QEctIvS5RpvGFZ_pEe9YSVWI4ICUSNs_deJ3Robg3OBTvOBDOwnXZtLPjXjw4dzHHahG9Ew?loadFrom=DocumentDeeplink&ts=221.55)**):**

Yeah, rates of IPV during pregnancy really vary depending on the data source that we're looking at. So, some population-based studies find that about 3% of pregnant people report physical violence during their current pregnancy, and that rate is higher, about 7%, for adolescent pregnant people. It's also, it's around 6% in American Indian and Alaska-native pregnant people. So, different rates depending on the population that we're looking at. We also see in the data that IPV can follow different patterns for people, so for some people, pregnancy can actually be a protective period almost, where abuse that might have been occurring before the pregnancy might actually lessen or change, but for other people, violence can begin or can worsen during pregnancy, and that could be perhaps due to a partner maybe doubting his paternity, or a partner trying to increase his level of control in a relationship during... Even in the best of times, pregnancy can be an unstable time, a stressful time for couples. And then, of course, for other people, the level of abuse stays the same in pregnancy.

**Katherine Atcheson (**[**04:59**](https://www.rev.com/transcript-editor/shared/B2xP3fUYAljklKrRr-cNQ3k7RWCHDZYsBpp4eo-oTkI0ha9vLA030PYDMEuxb0YbhsdKDmocee73QWnkpCPgelB7xOU?loadFrom=DocumentDeeplink&ts=299.73)**):**

And you mentioned this just a little bit in your last answer, but what sort of disparities in pregnancy associated homicide and intimate partner violence do we see in the US, such as among age groups, across racial and ethnic groups, or in geographic regions, that sort of thing?

**Karen Trister Grace (**[**05:18**](https://www.rev.com/transcript-editor/shared/u31glyWfgA_WUkI3wO3KcRuoKoSox9oYGfP9oigSJL9a5U7HtKad43Axzyzl7-Pgi_Wpwh-iUBpG6mMnUWZoZ2f0AUw?loadFrom=DocumentDeeplink&ts=318.3)**):**

So, consistently we see disparities in rates of pregnancy associated homicide with people of color, specifically Black pregnant people having a much higher risk. Younger pregnant people also have a higher risk for pregnancy associated homicide, especially adolescents. So, age 15 to 19, and then that's followed by the next age group, so people age 20 to 24. And then, looking at specifically intimate partner homicide, Black pregnant people also have the largest discrepancy in intimate partner homicide rate, between people who are pregnant and people who are not pregnant. So, Black pregnant people have intimate partner homicide rate that's actually eight times higher than Black non-pregnant people who were assigned female at birth. And then, the difference for people who are white, or who are Hispanic, is significantly smaller.

**Katherine Atcheson (**[**06:16**](https://www.rev.com/transcript-editor/shared/tpoin7DTYmw6T9Pc7OgFsoadeBcP2B0EMS_2noSFaI3owKsTkyNvs8oPj5A_8VMrJoxwQ6lTNr0E0kaoJd2zjwdxzUw?loadFrom=DocumentDeeplink&ts=376.5)**):**

And while this podcast is about preventing pregnancy associated homicide, we do know that intimate partner violence has a variety of health effects, even if it isn't resulting in a fatality. What are some of those health effects of intimate partner violence, particularly during that perinatal period?

**Karen Trister Grace (**[**06:38**](https://www.rev.com/transcript-editor/shared/jL5gvdaF23DcRIgIzLmEh5F7Q1MHLIAoxqcPjEjVDi02gGqPm30BLXnKwxQ1TclRXPhMwIUkSdRGWY9MRuJl6KcBO2Q?loadFrom=DocumentDeeplink&ts=398.46)**):**

Yeah, IPV has really significant impacts on health at all stages of life, whether during pregnancy or outside of pregnancy, during postpartum. So, we can see really the immediate direct impact as a result of trauma, so that would be things like fractures, lacerations, bruising, head trauma, and traumatic brain injury. And in pregnancy that physical trauma can result directly in perhaps a miscarriage, or it can cause a placental abruption, where the placenta separates from the uterine wall. But then, we also see chronic health conditions that result from IPV, and that can be due to the experience of just that chronic ongoing violence, and living with that constant and repetitive stress. And then, there's that associated stress response, which is the activation of the hypothalamic pituitary adrenal axis, the HPA axis, which, when you're not pregnant, it causes higher rates of headaches, and hypertension, diabetes, irritable bowel syndrome, fibromyalgia.

**Karen Trister Grace (**[**07:51**](https://www.rev.com/transcript-editor/shared/Qd7cscSfgN7Rncxruyjuq86Va0tJSXV-qv1K28CX6I6f8lfDL9Iv5C0yYGjnK5-G_GbFrhnHq2BiWzjETUtbL4WOIBw?loadFrom=DocumentDeeplink&ts=471.72)**):**

But then, when someone is pregnant and experiencing the activation of that HPA axis, we can see outcomes like low birth weight, small for gestational age babies, as well as preterm labor, preterm birth, and preeclampsia and other hypertensive disorders of pregnancy. Other health outcomes related to IPV during pregnancy and postpartum can result from possibly receiving inadequate prenatal care, or inconsistent prenatal care, and that can happen perhaps due to a partner restricting access to care, or simply avoiding care out of perhaps fear that the violence might be detected if they go in for care, and then this lack of prenatal care can result in things like poor nutrition, inadequate weight gain, it can see depression, substance use as a coping mechanism.

**Katherine Atcheson (**[**08:46**](https://www.rev.com/transcript-editor/shared/pVeM0cZ_hpsz97_s-3aKpWBcMRG7JNPcoOyegNmf1kcnb1NyK_3jFAVDPV12qFsi5ZaPxjlPdm-Zi6ivBAn6LEHaAGY?loadFrom=DocumentDeeplink&ts=526.26)**):**

Since Title X clinicians don't provide that obstetric or that prenatal care, what would be their role in addressing intimate partner violence with their patients, especially those who, again, are in that postpartum period, or maybe are trying to get pregnant, or have tested positive for pregnancy?

**Karen Trister Grace (**[**09:08**](https://www.rev.com/transcript-editor/shared/bMpjEzmHCQ9_xRCXWvcH7wh57VveSrwSiixf686TwPEN-t3u1Qg8ZZIks86M2VaTqZiHWa6d2zGXGYSSVjQQIz4Mh14?loadFrom=DocumentDeeplink&ts=548.1)**):**

Yeah. So, I think that the really important role for Title X clinicians is in screening. So, it's recommended to screen for IPV at least once per trimester when we're seeing pregnant people, but screening is also really important before pregnancy, after pregnancy, it's important to do it at multiple intervals as often as possible. And that's really because violence can change over time, it can stop and start, so screening just one time at one clinical encounter really isn't enough. It's also really important as Title X providers to really make sure that we have a physical environment that supports IPV screening, so that we have the ability to screen in private. And that might mean having a clinic policy that perhaps that all patients are seen alone for at least a part of their visit.

**Karen Trister Grace (**[**10:00**](https://www.rev.com/transcript-editor/shared/yxwpFVReWZd6d-prft5YzH0YJG82kvgxktTJgGEM-9hNB7SqYun_h2r5YFQsiPB-B3H-w9meEecjAkFsoswuzAOdIo4?loadFrom=DocumentDeeplink&ts=600.9)**):**

So, this might mean providing resources on IPV in private places, where patients are used to going without their partners, such as the bathroom. It's also important to screen multiple times because it can take time for an abuse survivor to be ready to disclose, for them to trust the provider and the health system to handle it appropriately. So, really, every time that we screen for IPV, we essentially are telling the person that this is a place that you can go when you're ready to disclose, even if today isn't that day. And then, the other really important component of care is providing referrals, connecting people to services, and really establishing those relationships with community services.

**Katherine Atcheson (**[**10:47**](https://www.rev.com/transcript-editor/shared/GCXsPYxplM3otbg-ZINZanBsM67oqBJijjpyex_J7X-g3ZirzMkn2lS0_Ki-BeppqyxVbbv-PlJ5DixHi-ZsmP6cW2I?loadFrom=DocumentDeeplink&ts=647.04)**):**

And what should clinicians do if they have a patient who comes in and denies physical abuse, but the clinicians see signs, such as healing bruises or injuries? Or if the patient mentions a non-physical form of abuse, such as perhaps financial abuse?

**Karen Trister Grace (**[**11:08**](https://www.rev.com/transcript-editor/shared/e07GHmbEyhoY4mZImkr1-rt-jUNG4LzBxVYKesckkC5vajCoEri7p_H553LcQyC-QrZFUCfaq6_wfTztzh-5xZCd6WE?loadFrom=DocumentDeeplink&ts=668.4)**):**

Yeah, the first part of that that you mentioned, taking care of patients who deny abuse when you see signs of abuse right in front of you, can be so hard for providers and nurses and anyone in the health system, really, who interacts with patients. So, first, I would say that this is why trauma-informed care is such an important concept. Trauma-informed care is a way of practicing that really recognizes how common violence and trauma is in the lives of our patients. And the recommendation is not just to screen all patients, but to provide resources to all patients. So, for example, we might say to patients, we know that experiencing violence is a common occurrence, so we offer all our patients this list of resources in our community, or this flyer about healthy relationships, and maybe we even offer two copies so that you have one to give to a neighbor, or a friend, because that's how common this is.

**Karen Trister Grace (**[**12:08**](https://www.rev.com/transcript-editor/shared/HcJyyh1vXSVM16Gt9-Ev_4SZbuqN2uaAN4scIhDG3K4jUqztCuKKN40DbgOUcz8Z1n6qX3dLnV3D4OCbqKFi_8cpT7U?loadFrom=DocumentDeeplink&ts=728.4)**):**

But then also making sure that it's safe for a patient to take those written materials, if we're handing those out to people. And then, when you see evidence of violence and the patient is denying that any violence occurred, I think the main thing is to recognize that it's that person's right to disclose or not to disclose, and the point of screening isn't necessarily to figure out the exact right words to say to get the person to admit to experiencing violence, and I haven't failed, for example, if I asked the question and the person said, no, that didn't happen. Asking the question again is letting the person know that this is a place where you can go for help when you're ready to disclose. And we can even state that explicitly, so we can say something like, I see you have some injuries that I often see after someone has been abused, and I'm really glad to hear that that isn't a problem for you, but just so you're aware, we do often see patients who experience violence, and we have a lot of resources available to assist them when that does happen.

**Karen Trister Grace (**[**13:09**](https://www.rev.com/transcript-editor/shared/lQOyldAsRzLSddY0vX0XCILFv1hKFqJH6xq1Knzje_eLKXi3yS2xPTr4zGoibAj1NZ14xJx-YPn-_ihXbWHK7TZgZRE?loadFrom=DocumentDeeplink&ts=789.9)**):**

And then for someone who reports nonphysical abuse, I think it's really important to validate their experience. And then for someone who reports nonphysical abuse, I think it's really important to validate their experience, that this is a type of abuse, this is harmful, there are health impacts of living with this kind of abuse. And there are services available to help you even if the abuse you experience is not physical. And then also informing the person that sometimes non-physical abuse can escalate or change to physical abuse. Speaking of non-physical abuse, is to just mention the concept of reproductive coercion, which as you mentioned in the beginning is my area of research. And reproductive coercion is a subset of intimate partner violence, or a type of intimate partner violence, is this phenomenon of various behaviors that interfere with reproductive autonomy.

**Karen Trister Grace (**[**14:08**](https://www.rev.com/transcript-editor/shared/X5pSV3YTYmQvIBXvEaWBGCBe6H847uJcn0IprvACYd0rMiRCL2ke3kKndxiisteBDhzNk8wK2XvbMP_eRRuNwR6XAU4?loadFrom=DocumentDeeplink&ts=848.88)**):**

So, usually it's behaviors that a male partner is doing, such as pressuring somebody to get pregnant, interfering with contraception, like flushing birth control pills down the toilet, poking holes in condoms, or it can be also controlling the outcome of a pregnancy, so coercing someone into getting an abortion who doesn't want to get an abortion, or preventing someone from accessing abortion who does want to have an abortion. And this is something that is really important for Title X providers to be aware of, in part because we know there's good evidence out there that people who experience reproductive coercion come in frequently for pregnancy testing, for emergency contraception. So, when we see someone who's coming in frequently for these things, it might be good to ask ourselves, what's going on with this person? And have a conversation with them about reproductive coercion.

**Katherine Atcheson (**[**15:02**](https://www.rev.com/transcript-editor/shared/7FpbT5UyuRGPwPbA692afLJcjYReElwPcg9_-fxteZK-IgChtklU7KcI_RIptepLneE_X8YE9Sr6agH-C5fnEg3IflI?loadFrom=DocumentDeeplink&ts=902.1)**):**

And what would be some of those top points for clinicians to address when they're providing that education and counseling to a patient in their clinic about intimate partner violence?

**Karen Trister Grace (**[**15:16**](https://www.rev.com/transcript-editor/shared/fE9vVIuM6GAxq4DvhuAyZoXEP7SHgwm-ZE-ypMNmAZrIByyvW00s13LIu45vVjokxzjXz2lLX2XNFKRV1Ge3gHq6G6w?loadFrom=DocumentDeeplink&ts=916.83)**):**

The first thing that comes to my mind is the importance of avoiding any judgment, and also the importance of asking questions about IPV in a way that conveys that I want to know the answer, that I'm not just checking off a box on the form along with all the other bazillion questions that we have to ask during a visit, and helping patients to identify behaviors as abusive, that they may not have realized were abusive. So, one thing that we know is common about IPV is that there's this cycle of violent behavior, followed by a period where the abuser might be really contrite, or loving, or apologetic. And we also know that there's a lot of gaslighting that goes on. So, a survivor might be told multiple times that what you think happened didn't actually happen, you're remembering it wrong, what I did is normal, this is super common, every couple experiences this...

**Karen Trister Grace (**[**16:13**](https://www.rev.com/transcript-editor/shared/79oST6Lo6XKVCoUyIs2KtAILqcf0meugCRrvBkVnKxo60r1wFp2nSDjd1hhhvnWO6TZCq0bWctp8U7BtDaXV82_SxXk?loadFrom=DocumentDeeplink&ts=973.68)**):**

So, helping patients to kind of name behaviors as abusive, and validating their experiences is a really super important role for providers. And then, it's a good idea, I think, to have a prepared response, such as, you might say, I'm so sorry that this happened to you, thank you for trusting me enough to share this with me, a lot of my patients experience things like this, and here are some resources that might be helpful. One other point I would say that's important is the importance of confidentiality, and providers should really know what the reporting requirements are for their state, and make sure to inform patients at the start of the visit if they are required to report anything, or if they're able to keep what is revealed to them confidential. And then, what the limits of that confidentiality are. So, in most states, providers are required to report suspected child abuse, but not necessarily required to report IPV, but that again, really depends on the state.

**Katherine Atcheson (**[**17:14**](https://www.rev.com/transcript-editor/shared/LMEbScatLMHQo4hCoWCK4gU435gbw39akck-k_db1lucbc-8Hj--iIHBmZpr1yL7Eu38FXEtoxhQP1rCdGnGtvxIejc?loadFrom=DocumentDeeplink&ts=1034.55)**):**

Since we know one of the most dangerous times for a person who's experiencing intimate partner violence is when they try to leave that partner, what are some best practices for clinicians who may be referring patients to services, or helping a patient develop a safety plan in order to make sure that that patient is, again, in as safe a place as possible when this happens?

**Karen Trister Grace (**[**17:42**](https://www.rev.com/transcript-editor/shared/mt-7rYeV32TKUff6vYTPPYYtgYTgE9utrEhnj6jE5zxP5AZElGoIBN57aDV-npZyGFkpUUiTAq3p1K4j_8DJBnuNtcQ?loadFrom=DocumentDeeplink&ts=1062.66)**):**

Yeah, that's a really important point. Absolutely the most dangerous time for a person in an abusive, and the time that they're most likely to be murdered by their partner, is when they try to leave. So, if you're asking yourself, why doesn't this person leave this abusive situation? It might be because they are in fear for their lives. And that's also why it's so important to recognize that when somebody denies abuse, even though we see the signs of abuse, we really need to respect that person's decision not to disclose, and then also trust really that they are the ones who are the experts on their situation, and on their relationship. So, that person has been living and managing to stay alive in this situation for, it could be months, could be years, and I've been aware of it for probably 10 minutes, or 15 minutes, of this visit.

**Karen Trister Grace (**[**18:37**](https://www.rev.com/transcript-editor/shared/1a1Cv4GqurvMkRJHFYDHelNlHwElQsQjmcvIXVL3SZw0E0_TEKAcclb3VNWqCNTn1lMl4v8J6oSXk3rSHGLbKJTH7YI?loadFrom=DocumentDeeplink&ts=1117.92)**):**

So, certainly, I am not the expert on how they should stay safe in their situation, they are more of the expert. As far as specifics of safety planning, whether during pregnancy, or outside of pregnancy, it's awesome if you have the ability to refer someone to social work in your clinic, that's really great to have those resources right there, but other specifics can involve asking the person about the perception of imminent danger. So, are there guns in the home? For example. Has the abuser threatened suicide, or threatened homicide? Those are very real threats to take seriously. Does the person need you to call the police right now, before they even go back out to the waiting room? There's a tool called the Danger Assessment, which was developed by Jackie Campbell at Johns Hopkins School of Nursing, which can be used to assess a person's risk for homicide.

**Karen Trister Grace (**[**19:34**](https://www.rev.com/transcript-editor/shared/XOBhJJxWn38RpYF4tmTPXxzOg-bO_W96QoYhDiitSAcgNKlyrDKt4ZKZDUW4dnPK7MPsHnAHlRMrP-g9wUsoOQoriHI?loadFrom=DocumentDeeplink&ts=1174.02)**):**

It's a series of questions that ends up with a score that tells you your actual risk for imminent homicide, and sometimes that can be really, really useful information for a person to have, to know how important is it that I act on this urgently? So, again, for me as the provider, I can ask the person how ready they are to leave, are they ready to take steps right now? What factors might be preventing them from leaving? I can be providing referrals, making warm handoffs to local services, such as domestic violence shelters, social services, housing support, and then just the importance really of validating the person's experience, and withholding judgment, and thanking them for trusting me with this information.

**Katherine Atcheson (**[**20:24**](https://www.rev.com/transcript-editor/shared/fqflNeaYgWoPCCxDwImGcmWBtbQ99B8dB2V2j801ahHgCBBp0VLTCy7DcySb--vpuY0K7rmKl6HHsozZupsX2F5kZ0U?loadFrom=DocumentDeeplink&ts=1224)**):**

Since patients experiencing intimate partner violence often have complex or multiple needs that need to be addressed, what is some good guidance around establishing those community partnerships in order to support those safe warm handoffs and referrals in order to get those patients the assistance they need?

**Karen Trister Grace (**[**20:47**](https://www.rev.com/transcript-editor/shared/RBSLtSrVARWH45Rl5SEtQbaVP_8zoxzY0mm6hb9dYNEs7_haH1jP_sSmh07GrnX6mnJKGoIXkX2aFacoDa6XFkI4id4?loadFrom=DocumentDeeplink&ts=1247.61)**):**

Yeah, those partnerships and relationships with local services in the community are so important to have so that we as the providers have the ability to really smoothly refer a patient who needs that immediate expert support and help with leaving an abusive situation, so that they can have the many different needs that they have addressed, like housing needs for their children, access to food pantries, perhaps advocacy in the criminal justice system, or assistance receiving orders of protection. But also so that relationship can really be reciprocal, so that when an IPV service provider has a survivor who comes to them who needs healthcare, they can also refer back to us. So, the person might not necessarily need an emergent trip to the ER for some sort of injury related to violence, but it's possible that that person, and likely in fact, that the abuser has prevented them or prevented their children from accessing healthcare regularly, and so they might have really significant needs that we can assist with.

**Karen Trister Grace (**[**21:58**](https://www.rev.com/transcript-editor/shared/EqzjC-4SfK-ox39F1qzGsMED-ybK7fKkBcqCEjoTk8JvczzGbFiWYBEaJuwumOk9bbaG0YJ70yuU6q61LVxX9-rEYc0?loadFrom=DocumentDeeplink&ts=1318.89)**):**

And then, when we're establishing these relationships, we want to know what's the best way to smoothly hand a patient off to that service provider so that the person doesn't get lost in the shuffle. And we might need to know other details such as what languages are spoken by staff at that agency, if there's any specific populations that they are particularly equipped to serve, such as LGBTQ patients, or adolescents.

**Katherine Atcheson (**[**22:23**](https://www.rev.com/transcript-editor/shared/BtUm1v-u-YKAyPP2uR89_vl6Wq3op5oNtw6D_7Gw_1pUiEn6SK01FJqf_xMQ-b7Hku87It66DbXCxl-JGU3vq57c6TE?loadFrom=DocumentDeeplink&ts=1343.16)**):**

Are there considerations a clinician should keep in mind when seeing a client who is recovering from intimate partner violence, or has experienced it in the past, and is a survivor, when they provide any sort of sexual and reproductive health service?

**Karen Trister Grace (**[**22:37**](https://www.rev.com/transcript-editor/shared/L5nqiaAnrw-COrzTweNYetOjS0EAEHhhooQrUaEYrB3Fm6NDjoqFx8huxFBnMkh-4SanvgMxBr-LR-UzkiRVT8eEZ5I?loadFrom=DocumentDeeplink&ts=1357.74)**):**

Yeah, that's going to be, again, that importance of trauma-informed care, and really recognizing how common trauma is in the lives of our patients, and really entering every clinical interaction with that in mind. So, it's really being mindful of the power dynamics, especially that are there in a patient provider relationship, and things that might make the person feel really vulnerable, especially when we're providing the kind of care that Title X providers provide, or pregnancy related services, those types of visits are inherently more vulnerable for people. So, the importance of creating an emotionally safe environment. And that might mean things like having a warm demeanor, greeting the patient when they're fully dressed, and not walking into the room when they're already undressed, staying at eye level with them, and perhaps explaining what will happen during the clinical encounter.

**Karen Trister Grace (**[**23:32**](https://www.rev.com/transcript-editor/shared/P9oLuns6W2gv97gpyX7vN6ORmA14B0WveNWtQCt6uk1lONpRGEL6BsX7KTDTBBxzhRvP0ubtwoHm9IbeHW4R6qkIsHA?loadFrom=DocumentDeeplink&ts=1412.91)**):**

And especially important is informing the patient that they can pause the exam, or stop the exam altogether, at any point if they are not comfortable continuing. And again, I think that this question really highlights the importance of universal screening. So, not just screening the teenagers who come to our clinic, or the people who come in with a partner who is obviously really threatening, so offering universal resources, universal screening to all patients regardless of what they report. But of course, as I mentioned before, making sure that it's safe for them to take whatever resources we're handing out, if we're giving them a physical piece of paper or something that a partner might be able to discover.

**Katherine Atcheson (**[**24:17**](https://www.rev.com/transcript-editor/shared/WFfAZq2QmNiBDWBlTQnJk5vgOVjUemR6GTd80a_gWr-bClx1VjI7fO30eUUC0LX9y8tYKeEmS6qcp5qBhWaINJwrHjg?loadFrom=DocumentDeeplink&ts=1457.37)**):**

And where are some good places for clinicians to go to learn more about intimate partner violence, especially as it relates to sexual and reproductive healthcare and pregnancy? And are there also good resources for clinicians that they could refer to their patient to maybe experience in this, that sort of thing?

**Karen Trister Grace (**[**24:37**](https://www.rev.com/transcript-editor/shared/bjacKV8tusHtCJr452KDu71z0FoYraYOJgRuL0dOEz9vMKHtXbu4yLkt4rjQrtvyGlE-DOjg1reT8mXFC-FcR-uiWK4?loadFrom=DocumentDeeplink&ts=1477.11)**):**

Yeah, a simple Google search will give you a lot of awesome options, 800 numbers, hotlines. I would say that my go-to for... Well, for data, my go-to is the CDC, and specifically the NISVS data, which is the National Intimate Partner and Sexual Violence survey data, really great data on this topic. But the organization that I think is really the best resource, especially for clinicians, is called Futures Without Violence, and they have a great website, but they have specifically an entire health resource center on domestic violence, it's called. And they provide amazing resources for providers and for health systems, that's really focused on that intersection of health and IPV. So, they have training for providers, they have sample scripts available for providers, because sometimes we just are not sure we're going to know exactly how to respond the right way, they have patient education materials, webinars, and they have a really great conference that I highly recommend, called the National Conference on Health and Domestic Violence, a great conference for providers.

**Katherine Atcheson (**[**25:45**](https://www.rev.com/transcript-editor/shared/2s1FGkM_GiTtM7POs48b3uxC78iAzMS5Am-s0EHBKawrh3AtWcb7rxzjJMtw0EYcU2S3qiJLMk3peoz5_vezYkwL140?loadFrom=DocumentDeeplink&ts=1545.54)**):**

Well, we've had a wonderful informative chat here, but before you go, what would be your top takeaway for our listeners to return to their clinical practices with, as we're ending here?

**Karen Trister Grace (**[**26:00**](https://www.rev.com/transcript-editor/shared/kNaJjxiXj_yCaP_upxNEqqPErbt8v1yNtIqffvmG53Hn4UhMNP_y5hai4zccDLvfLmItXIJkNmp-IJAMcnRJ18n3oF0?loadFrom=DocumentDeeplink&ts=1560.78)**):**

I think that my top takeaway is going to be about screening for IPV, and to really remember that screening itself is the intervention. Primary goal isn't finding a way to get people to disclose abuse, it's to let people know that this is a place you can come for help when you're ready, or if this is ever a problem for you. And also, to help people identify abusive behaviors, which is why it's helpful instead of asking vague questions like, any abuse in your life? Or any history of violence? To instead ask questions that have specific behaviors, such as questions like, is there anyone in your life who threatens you, or talks down to you, or hits you, or slaps you? Specific behaviors that can really help people to name the behaviors that they're experiencing as abuse.

**Katherine Atcheson (**[**26:54**](https://www.rev.com/transcript-editor/shared/lmXSGwVKaxvKDscGM-j4IhCKsDINaaQOb-QF2pGb8KwDJbk0UGViiYZuV1RVpHDbK7gDmeqyPzaA2_7DqrCoLE_Ssqk?loadFrom=DocumentDeeplink&ts=1614.06)**):**

Well, thank you so much for joining us today, Dr. Grace, and for sharing your time and expertise.

**Karen Trister Grace (**[**27:00**](https://www.rev.com/transcript-editor/shared/mpfsI7JiSkTHsd93-_j1FJqRKx81LnJxz41G0pgEQx6Cq3ztDDfc81VUfIjBX2pDslxUEgDQBZBhvoTK3Yyj3la0kTA?loadFrom=DocumentDeeplink&ts=1620.24)**):**

Thank you so much for having me.

**Katherine Atcheson (**[**27:02**](https://www.rev.com/transcript-editor/shared/iCNo-muqw5NurobIfmSaceTOamcP6Kg3grPSSgMvG1GkiaVFv37WNj2EIKO5a74ohlV863NuKmM-ibW3W0WM8k3t0eE?loadFrom=DocumentDeeplink&ts=1622.07)**):**

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**Katherine Atcheson (**[**28:07**](https://www.rev.com/transcript-editor/shared/zm2M4_VHZenLVbBnVOZrWU4Ne9CfW2ZO3n6qPInEqM5ifdKjDwOB3tf1mvq3lbbKQV0uTgI4PKCROHrir9akUchNQ-U?loadFrom=DocumentDeeplink&ts=1687.05)**):**

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