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INTIMATE

PARTNER VIOLENCE, PART 1
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>> THOM PANCELLA: And good afternoon everyone, from St. Louis, Missouri and the Institute of Mental Health. I'm Thom Pancella with MIMH. Thank you for joining us for our program, the first part of intimate partners violence. Next week we'll do the second part and hope you'll join us for that as well.

I'm pleased to introduce our speaker and I'll do that in a second, but I want to explain the screen

geography to you. If you've joined us for the first time we welcome you. Some of you are familiar with this part of the talk. Below the video window we welcome our captioner. We're pleased to provide the service to anyone who needs it and wants to take advantage of it. Under that you'll see several links. If you're interested in continuing education credit for today's program, there's a link to purchase CEUs under the video window. Below that a couple more links, one is a link to the slides as a PDF. Pop them up in a separate window if you want to follow them that way. They'll also appear on the video window itself but that's up to you if you want to do that. As well, you'll see a link to the project DEAMHI Web site and we'll explain all about that as we get going so you can follow that.

If at any time you have questions or comments or other feedback for us, to the right there is a chat window. Use that chat window to submit questions. We'll hold those questions to the end of the presentation block, but I encourage you to submit them at any time, because we'd like to keep them here and we'll be ready to ask them for you on your behalf. So you can do that at any time. The first time you type in a question or a comment you might have to enter a nickname for yourself, but you should never have to hit the log-in, just enter it and click say and enter a nickname the first time.

Now I want to introduce Belinda James to you, and it's always a great pleasure to introduce people who have a terrific passion for the work they're doing. You're about to experience that. She's a passionate advocate for children, youth and families. She's a native of St. Louis, Missouri and received her Bachelor of Arts from Southern Illinois - Edwardsville, master's degree from The Brown School of Social Work at the St. Louis University here, and family development credential from the University of Missouri - Kansas City as well as certification in trauma-focused cognitive-based therapy for the University of Southern California -- that's the second time I've said Southern California -- South Carolina (laughter).

She's been facilitating youth leadership and apparent education workshops and training in mental health 101, communications, customer service, group dynamics, motivational interviewing, art of de-

escalation and trauma recovery. She's taught in the field of social work as an adjunct instructor at the brown school. Currently the chief executive officer of DEAMHI Corporation, to provide awareness for mental health things. She counsels women who are homeless, pregnant and may have extensive trauma backgrounds. Belinda thank you for joining us and the floor is yours.

>> BELINDA JAMES: Thank you, Thom. I want to start off by thanking the Missouri Institute for Mental Health for the opportunity to share some information on intimate partner violence. I'm very humbled by that opportunity. It is my hope that this information will be a platform for further discussion about the topic and certainly an encouragement to reach out for resources and maybe even look at collaborative efforts for community partners. I'm representing DEAMHI, which is a nonprofit that provides a great deal of mental health education in the community. We also address intimate partner violence issues. We have support groups for adolescents and we do a great deal of life skills programming for middle, high school and college students. In addition, we do a great deal of professional development training in the community and this is an exciting opportunity for us to talk about intimate partner violence.

As Thom mentioned, this is a two-part series. Today we'll talk a great deal about what intimate partner violence actually is and how it affects those that are involved and next week's training will really be a practical experience for participants where you will receive tools that you can actually use with your clients on strength-based practice addressing the issue of intimate partner violence.

Let's go over some workshop objectives so we're clear about what it is we're going to cover. Today we're going to define intimate partner violence. We are going to identify the effects that intimate partner violence actually has on all that are involved and then we'll take a look at some mental health issues associated with the intimate partner violence and begin to address some of those barriers that our clients actually have, including some provider barriers, and that's the part that I really hope that we as providers can really do as some self-assessment, so figure out what parts we play that are helpful and

inviting, and what parts would be a barrier for our clients to access resources.

So let's talk a little bit about what intimate partner violence is. And I am a mover and shaker in a presentation so I'll let you know I'll kind of be flowing. So I'd like for you as you are sitting at your desk or at your computer, think about what intimate partner violence is. What are some specific things that you can actually identify as intimate partner violence? So we can definitely say physical abuse. Emotional abuse. Other examples? Verbal abuse. Psychological abuse.

Okay. So those are definitely some to name a few. Intimate partner violence is really a pattern of coercive behavior that attempts to take power and control over an individual in a relationship, and so it could be a number of abuses from physical to emotional abuse to psychological to spiritual abuse, to intimidation and coercion, to actual sexual abuse, economic abuse. It could also be deprivation and stalking, and more of that verbal. So all of those are included in the intimate partner violence. All of them are about power and control and hurt so as you think about what intimate partner violence is, who do you think is affected by that? Everybody. It's everybody that's affected by it.

So as we talk about what everybody actually looks like, it could be any age-group. It could be any social economic level, it could be any ethnic or racial group, any educational background, any sexual orientation. There are no barriers. Intimate partner violence affects all. And one of the things that we do want to focus on is that we don't want to label, and we don't want to tie into any of the assumptions or biases that are already out there about intimate partner violence. It affects everyone. However, it is important to point out women represent the largest number of intimate partner violence survivors.

So as you look at pictures, I just really want these pictures to resonate on your heart of who intimate partner violence actually affects. It could be the couple with the child and the child is present. It can be traumatized by that violence. It could be a same sex couple. It could be a couple where the female is the abuser and the aggressive one. It could be in an adolescent relationship. As we talk about intimate partner violence it's also important to talk

about the effects that the violence has on a pregnant woman and her fetus.

So let's talk about some statistics. One in four women report intimate partner violence in their relationship at some point in their lifetime, and that's from the Centers for Disease Control. 15 1/2 million children witness intimate partner violence in their household. 62% of 11 to 14-year-olds say they know friends who have been verbally abused by a boyfriend or a girlfriend. And one in five 13 to 14-year-olds say they know friends and peers who have been struck in anger by their partner. So again, sending that message and just letting that resonate on your heart, that it is any group. There are no special groups that are not affected by intimate partner violence. It's any group.

Let's talk about the elderly. The elderly is not a group we talk a lot about when it comes to intimate partner violence but they're as affected as any other group. Men are as likely to be abused as women, however, elderly women sustain more serious damages, more serious effects from the intimate partner violence. In the LGBT population, in 2003 there was a study done that identified 6,523 LGBT individuals that reported intimate partner violence in their relationship. Of those 6,523, 44% of them were men. 36% were women and 2% were transgendered. So again, anybody is affected.

Male survivors, as we talk about -- survey -- as we talk about male survivors of intimate partner violence they're less likely to report incidents of abuse, for fear of being belittled, fear of being judged. So we have a lot of males that aren't reaching out for resources when they could. So we want you to encourage any male survivor, it is okay to share your story. The supports are out there.

Violence and pregnancy is also a very sensitive issue. As we know that fetus is exposed to stress, and so when a woman is pregnant and she is involved in an intimate partner violent relationship, that's huge. So we're looking at 4 to 8% of women that report violence during their pregnancy, and that affects about 324,000 women every year. So that's the woman and her child.

So issues associated with intimate partner violence and pregnant women include delayed prenatal care, smoking, alcohol and drug abuse issues, and sometimes

before the pregnancy is actually unintended pregnancy because of the sexual abuse that could happen in the relationship. So direct effects to the fetus include spontaneous abortion. There could be fetal injury or death from the maternal trauma and indirect effects are maternal stress, maternal smoking and then the alcohol or substance abuse uses.

So we know that intimate partner violence has a very strong effect on our children and some of those effects include low birth weight, an exaggerated startle response, so you may have a young child that jumps very quickly as a sound, a noise somewhere in their house because they have been exposed to that violence in the home. It could be somatic complaints, so you could have a child that complains a lot of stomach aches or a lot of headaches, and so if you know that your child has been exposed to any type of violence in the home, that is certainly something to look for as that could be a sign that the child is really suffering from that trauma.

It could be regression in toileting or in language, so here you have a child that developmentally is moving forward like they're supposed to and then all of a sudden they revert. They are wetting their pants. Language goes from using full words to maybe more of the baby language, and you as a parent or caretaker are stressed out about that. So I encourage you to think about any particular trauma that that child may have been exposed to because those can be direct indicators of that violence that they have experienced. It could be sleep disturbances.

So if your child has a hard time falling asleep or if they fall asleep and they pop up a lot, again, those are just signs to be aware of, because if you don't necessarily know the effect that intimate partner violence has on a child in particular, you may just think developmentally that's just part of what they're going through, maybe it's nightmares, and they're just not able to settle. But if you think about the fact that, you know, two years ago she was a witness to a lot of violence in the relationship, that's certainly something to think about.

There could be difficulty attaching to a caregiver, so if a child has a hard time emotionally connecting to an adult, a hard time being comforted by an adult, that can also be a direct sign of that intimate

partner violence. There could be some hypervigilance as well, so this is where a child is overly sensitive to the dynamics that are going on in their environment. So overly sensitive to noises, overly sensitive to voices and touch and has that startle response again, that is a indicator of direct exposure that intimate partner violence has. There could be separation anxiety where it's hard for a child to separate. We know some of that happens anyway naturally with children, but if it is this very deep layer where it is so difficult for the child to separate that it just becomes emotional and they are distraught by that, and you know that there has been some intimate partner violence exposure, that is certainly something to think about.

And then we also can look at some eating disorders that can come about in children as well. So we want to just be aware of that and we certainly don't want to dismiss that. A lot of times I'll hear some clients say, well, she was so young, she doesn't remember that, or he was -- he doesn't remember that because he was only 1. Well, now he's 3 and he's very aggressive in his behavior. That could be from his exposure to that intimate partner violence. So certainly something to think about. Not only for the parent or the caretaker but for us as the providers as well, just being able to recognize those signs so we can do some psycho education with our clients on increasing awareness of what those signs actually look like.

Here are some more consequences for children. Boys are more likely to become abusive adults. Girls are 300 times more likely to become involved in an abusive relationship if they have been exposed to intimate partner violence. And then people abused as children are 18 times more likely to commit suicide. Again, long-term effects of exposure to that intimate partner violence can turn into some mental health issues and certainly some behavioral issues with our children.

Experiencing abuse as a child has been associated with things such as depression, substance use issues, poor school performance and high-risk sexual behavior. So as we move through this discussion and we prepare for next week's discussion on creating an opportunity to have conversation about intimate partner violence, I really encourage people to know the backgrounds of your clients and assess in a way that is comfortable

for them. So I challenge those of you that are watching today that don't necessarily assess for intimate partner violence, and I'll challenge you to think of ways that you can infuse some conversation into your assessment process to be able to actually capture the essence of maybe some reporting that your clients can do around that particular issue. It's very scary. Excuse me. It is a worrisome issue that sometimes our clients fear will cause more damage if they say something about it than not, but by us asking the question, it actually gives them permission to talk about it. So I really continue to encourage you to do that.

Another factor with children exposed to intimate partner violence is that boys who witness violence against their mothers are ten times more likely to abuse in their adulthood, compared to boys that grew up in nonviolent homes. So it does affect behavior. It does affect a child's view of the world.

So let's talk a little bit about behavioral affects on children and teenagers. As you think about young people, sometimes young people will overcontrol their emotions, and what I mean by that is they will try to internalize that. They will not share all of the feelings that they have. They will not necessarily be as truthful or cover up some of the struggle because it's hurtful and they don't know how to process that, and if they haven't had the opportunity where they hear people ask about it, then they're less likely to talk about it.

Some young people undercontrol their emotions, so they externalize it. So they become more explosive. So externalizing it means they will explode. They will throw temper tantrums. They will have lots of fighting in school. So if you have a child that has become one identified as a troubled child in school because of maybe problems with their peers or they are fighting a lot or they're getting suspended, I really encourage you to ask whether or not they've been exposed to intimate partner violence, because it could actually be the case. And we don't know unless we ask, and unfortunately sometimes our young people are labeled incorrectly because the social worker, the counselor, the teacher, they are not aware that intimate partner violence actually takes place in the home, and so that's why it's just so important for us to really ask that question. And Part 2 -- and I

really do encourage all of you that are participating in this Webinar now to participate in next week's Webinar as well, because we will be taking this information and really turning it into some practical steps of how do you do that? So you hear me say now, ask the question, so I'm encouraging you, but next week's session will give you the how's, will give you the strength-based language to use in order to do that.

So as we're talking about effects of intimate partner violence on everyone, children in particular, let's look at some factors that really influence our survivors. So our survivors are the individuals that have been through the abuse and they're no longer in the relationship or they're still in that violent relationship and trying to deal with that. So some of those factors -- before we get to the factors, let me share with you this quick story.

This is a picture of a child that drew their feelings about intimate partner violence. So if you really want to know what children think about any exposure they may have had, ask them to draw. This is a drawing from an 8-year-old, and this drawing actually specifies this child's feelings of his father, and he wrote in Spanish (inaudible) my father, because he often gets angry and drunk and his eyes turn red. That's his depiction of his exposure to intimate partner violence. So again, we always want to ask, we always want to assess, because we don't know what people go through. And there is a lot of masking that goes on for plenty of reasons.

And let's talk about some of those factors that influence our survivors. There could be a loss of status. That can be a factor that influences survivors. It could be a money issue. One of the reasons that an individual may stay in that relationship is because maybe they focus on the good times. There were good times in that relationship. It wasn't always bad. And so that could be one of the factors that keeps people in. It could be because of family, I don't want to break up my family, even though I'm concerned about this violence, I'm hurt by this violence, what would that do if I break up my family? So that's a huge issue for people to think about. Religion and other cultural beliefs can be a factor for survivors. It could certainly be about the children, even though they are exposed to it,

sometimes people will think that they'll lose a parent or they'll lose that stability, I don't want to change that. And a lot of it is fear. It's fear of the unknown. I don't know what life will look like if I leave. Despite the fact that I really want to, because this is hurtful. But the hurt is predictable. I'm speaking from some of the clients that I do therapy with, where I hear them say, the hurt is predictable. I understand the cycle of violence now, so it's predictable and I know what to expect. But change, I may not know what to expect. So just really encouraging our survivors to know that it is okay to make that change. You have resources out there that can help you do that.

But let's take a look at the breakdown of power and control, because as we -- we started off, we identified what intimate partner violence was. It's a pattern of coercive behavior with an attempt of power and control on one person in the relationship. So there are some very intricate components to the cycle.

The use of coercion and threats, could be that the partner is making or carrying out threats to do something to hurt the other person or to hurt their family. Using economic abuse. It could be that the abuser controls the money in the relationship, and so that survivor is in that relationship because there is no other monetary support. It could be using male privilege, treating the survivor like a servant, making all of the decisions, acting on their behalf, speaking for them so the survivor does not have a voice. It could be using the children. It's a guilt trip. If you leave me what will happen to our children? I can't believe that you would even think of doing that. Remember, it's the power and control. Minimizing and denying blame, making light of the abuse. It's not that bad. I only hit you twice and I told you I didn't mean it. So don't make such a big deal of it. Power and control. Using isolation. So the survivor is isolated from supports. He or she is isolated from their family, isolated from their friends, isolated from any social networks, any supports in the community, so they're feeling very lonely and they're feeling as if the abuser is the one that they have to rely on.

Emotional abuse, so it could be put-downs, name-calling, making that individual feel like they are less of a person and no one else will want them, so

why would you leave? That's part of the intimate partner violence and power and control, and using intimidation. Of course making that person fearful as part of the power and control. This is the cycle that we're dealing with. I encourage people to think about this cycle before you make a judgment, because, quite honestly, there have been lots of judgments made about the person that remains in that hurtful relationship, and some of them might be, I don't believe that that person is still there, why doesn't he or she just leave. I would never deal with violence in my relationship. Those are very judgmental statements. And if that survivor feels like they're being judged, they're not going to talk to you. They're not. We're losing that opportunity to support them, to motivate them. So please, just think of that and challenge others when they -- when they make a judgmental statement, challenge them to think about the cycle and all the factors that play into intimate partner violence.

So let's talk about more of the phases of the violence, because there are four phases. One is a calm phase, everything is okay, everything is peaceful, the abuser is acting like there's not a problem. But then we get to a point where there is tension that builds. There is anger that builds, there is aggression that builds, and instead of talking it out it actually comes out through hurts, physical hurts, emotional hurts, verbal hurts. The abuse occurs and then we move into the reconciliation phase, I'm sorry, I did not mean for that to happen. It's my issue over here, it's my issue over here, it's not me. So it's the excuse-making to allow -- or to make that survivor remain and accept it.

So it is a cycle of violence. So as we think about the cycle, I would like to encourage each and every one of us to think about a cycle of change. We know there's a cycle of violence, four phases we just talked about. But let's look at it as a cycle of change as well. So in considering this a cycle of change, it is important for us to look at intimate partner violence as a public health issue. This is a public health issue because there are medical costs. There are direct costs, there are indirect costs for a survivor.

So for a female survivor, intimate partner violence is actually greater than breast cancer, cervical

cancer and diabetes. I just want you to think about that. Let that sit on your heart for a moment. Intimate partner violence for a female survivor is more prevalent than breast cancer, cervical cancer and diabetes. That's major. That's major. Nearly one in three women will report an intimate partner violence experience in their lifetime. That's one in three. So if you were sitting in a room right now with six female colleagues, two of them in their lifetime, according to the statistics, will report intimate partner violence at some point in their life.

Based on some data from the Centers for Disease Control in 2003, intimate partner violence direct costs for the United States was over \$8.3 billion, for medical care alone, for the needs that the survivor had from that violence. The indirect costs, such as lack of productivity, being at work but you can't focus or calling off of work because of the violence, is over \$1.8 million.

Mental health care costs are 800% higher for those that are abused versus those that are not abused, and we have a lot of mental health issues in our community already that are not even tied into intimate partner violence. So I just really encourage people to think about that. In addition, injuries that are sustained from violent episodes can be linked to arthritis, migraines, stomach problems, pregnancy complications, chronic neck and back pains, sexually transmitted infections and drug use. This is why it makes it a public health issue.

But I want to encourage us that this can be a cycle of change. We can be a part of a cycle of change, but in order to move towards that stage of change, we do have to understand what those barriers to resources are, what are the barriers that clients actually go through. Let's talk about that.

So provider barriers and client barriers. According to the division of injury and violence prevention, the office of family health services, and this is from the Virginia Department of Health in 2009, there was a survey that was done to address intimate partner violence in the health care setting, and from that survey 95% of providers have never attended a training on intimate partner violence. I'm sorry, I did say 95%, just in case someone misheard that. 95%. That's huge. That means those providers are not assessing for intimate partner violence in

their health care setting, which we would hope would be a safe place for a survivor to share that information.

Out of 1,053 of those surveys completed from social workers, 42.1 stated that they don't have time to ask about intimate partner violence in their practice. I'm sorry, yes, I said it, they don't have time to ask. Again, just in case you didn't hear that part.

We need to take the time to ask. This is my challenge from one practitioner to another, please take the time to ask the question, because that could be the first invitation that a survivor has ever had to address the issue. And if a survivor never hears anyone ask them about it, then they may not know that it's okay to talk about it, because they're already fearful for a number of reasons. So as providers, how are we part of the problem? This is self-assessment, and self-assessment is not always the most comfortable but it is necessary.

Violating confidentiality. Do we talk about it in our front office with our coworkers. Normalizing victimization. Well, you know, here we have another one that just came in and said that she, you know, has dealt with some violence in her relationship, or here we go again, he just came in and said his partner throws things at him all the time and curses him out. They just need to get with it. So you're normalizing it. Ignoring the need for safety. So if someone says to you they're dealing with intimate partner violence, are we asking the question of whether or not -- where they're going tonight or where they're going when they leave our office as a safe place? Those are some basic questions to think about. Not there's no respect or no autonomy so there's more of the power and control from you, from us, I'm including myself in this, because self-assessment is something we all need to do on a regular basis. Our words, are they words of partnership with your client or are they words of power and control?

Here's what you need to do. That's a power and control phrase, compared to "let's kind of talk about what you think might be helpful. What do you think you need right now?" Because there is power in our words. If we trivialize or minimize the abuse, then we're almost blaming the survivor. So these are our own barriers, as a practitioner. So think about the barriers we've already discussed about the survivor,

the loss of status, if they share their violence, experiences. The money issues, the concerns about their children, concerns about their family. Those are their own personal barriers, but we also have some in our organizations as well.

So one of the things that I certainly would like to encourage you to think about in your practice, in your offices, on your intake forms, are just words. And we can do a day-long workshop on words alone. Avoiding labels. So avoiding labels such as spouse abuse. Avoiding labels such as battered woman. Avoiding labels such as emotional abuse or victim versus survivor. They're survivors. They've been through some things, or they're going through some things and they have a story to tell. Victim is more of that negative labeling that may hinder someone from sharing what they need to share.

So those are certainly important key pieces to think about, and I challenge you on the language because in our Part 2 serious we really are going to go over some very practical ways, some actual specific verbiage that you can use when talking to a client that is strength-based, that invites them into the conversation around intimate partner violence, in a way that lets them know, this is a safe zone. This is a nonjudgmental environment, this is your platform to be able to release.

So there's a process there we're going through, we're just laying the foundation now of what intimate partner violence actually looks like. Next week we're really going to jump into the how do you address it, the how's.

So as we think about creating opportunities to have the conversation, which is Part 2 of next week, let's think about the first step. Research actually says that intimate partner violence survivors are often judged and they're not believed and they're blamed by professionals. Now, for those of you that are very focused on a strength-based practice, that touches our hearts because we just can't imagine that a professional would blame or judge someone. We can't imagine that. That's really not supposed to happen in our fields, but it does. So it's no wonder that our survivors are hesitant to bring up any of the violence, because if they hear judgmental comments already, they're surely not going to.

Think of a time when you wanted to share something and then someone made a comment to you that was judgmental. I bet you held back. You might have held back. Often people who experience intimate partner violence lack a support network. They may only have health care providers that they feel are their supports, but guess what. The health care providers might not be asking, and that's the only support that they have, or guess what, the (inaudible) that their child is in might be the only support they feel they have. But are you asking it? Think outside of the box. If you run a program that is an after school program for children and youth, do you have a form that asks what the family's needs are? Do you ask if there is intimate partner violence in the home? Or do you just focus on the child's needs and activities they would like to be placed in, I'm going outside of the box right now. So go with me on this. Think creatively about your process of connecting with clients and building relationship from the beginning, from the moment your staff answers the phone, to the moment that they hang up, because we want to challenge ourselves to put a client in a position to walk away saying, I am so grateful that I talked to them. That was so well worth my time and it hit my heart.

So in Part 2 of our series, you as participants will use a strength-based model to really focus on healthy relationship building, to focus on a way to bring a client into a conversation without feeling judged. We're going to discuss the process of assessing for intimate partner violence, what does that look like? What specific questions would you ask? They don't have to be long-winded. It doesn't have to throw off your whole intake process and cost your organization a lot of money to redo your paperwork, but it certainly is something to think about. We'll practice a therapeutic model called motivational interviewing, which is a technique that invites a client in to be a partner in this process.

Think about a client who's coming to ask for assistance. It's very courageous for them to get to that point to even say to themselves, I'm going to go to the ABC program and let them know that this is what my family needs. That's huge. Huge. I hope that we're all humbled by that opportunity to connect with a person when they get to that point of asking for help. It's such a sign of strength.

When they do, we want to be able to use this motivational interviewing technique to make them feel like they're a partner. It's not a power over. This is a power with. This is a partnership that we're building, and so we're going to practice that. We'll have a tool that we'll actually be able to use during the training. You'll have access to it on the Wisconsin. And we will practice what that feels like using that with your clients. Then we're also going to talk about using an abuse assessment tool that you can actually infuse into your paperwork process. So again, not a cumbersome process, not a process where you have to change all of the dynamics of your intake and your paperwork, but just a way for us to include this in our process.

So as we think about change and as we think about cycle of change, we think about assessment to ask about intimate partner violence, I really would like to encourage us to think of what it feels like to be our client. And we do this, but do it regularly. What does it feel like to be our client? One of the things that I always share with clients is, I'm not on the other side of the table from you. I sit on the same side of the table as you. I'm human, you're human. Let's cry together. Let's breathe together. Let's figure it out together. This is a partnership. And I really challenge myself to do that because of this statement here. This came from a family member in a focus group back in the late '90s. And it says, rich people can decide what they want to do. Poor people are usually told what they have to do. Now, I want you to switch that because we're not here to talk about poor people, but what we are here to talk about is a survivor, a person in need. And so sometimes the person in need can be told what to do or can be judged because of their need. I put that statement up there specifically to throw you off and make you think about that.

We want our clients to feel a part of this partnership process. I invite you to think about what that looks like for your organization, for your network that you're a part of, for your parent or social group that you are a part of, for your community, for your neighborhood, for your faith-based organization. What does that look like? I challenge you to think about that. Write it down. Come back to next week's session so that we can really talk about

what that looks like, and is there potential to tweak it just a little bit, as we think about partnering with our clients.

Questions?

>> Yes, we do have questions. I would encourage people to take advantage of the chat window to the right of the video screen to submit your questions or comments. First question that's come in, do you think that the social work field views IPV as such a special, specific topic and therefore does not encourage trainings for those in social work positions? What's your opinion on the disconnect?

>> BELINDA JAMES: I appreciate the question. It is a thought-provoking question. I do get the sense that intimate partner violence is a specialized component of our social work field that places us in a position to only offer trainings in a very specific way versus broadly. So as I think about social work education, there should be a mandatory class on intimate partner violence, because I guarantee you as a social worker you're going to run across that at some point. In the medical field, there should be a mandatory course on intimate partner violence, because at some point one of your patients will come into your office with an intimate partner violence issue, an injury, an emotional scar. So I do feel like it's a specialized field, but I do want to give the field of social work credit. I do think there is more infusion of this discussion into our work, but I almost feel like it should be mandatory. It's still optional. And if we are preparing social workers for the field, it shouldn't be optional, because we're going to come across it at some point. And when we have the option of saying, I'm not dealing with that -- will we have the option of saying I'm not dealing with that? We probably will not. So I thank that person for that question.

>> THOM PANCELLA: There's a question from someone in the room here.

>> Hi, Belinda.

>> BELINDA JAMES: Hello.

>> I want to know, how important do you think it is for as we're working with the women, the women when they come into our services for IPV services, also to have a component in their service that works with the children as well, because oftentimes we find that as we're working with the women, that they can focus

mainly on them -- they can't focus mainly on them because of the effects of the IPV with their children, that they can't focus on a lot of things for themselves. Thank you.

>> BELINDA JAMES: Sure. Thank you for the question. I think it's imperative for any survivor that has children to have some services offered for them. Whether they have been directly involved in that intimate partner violence exposure or they see their parent, they see the mother, they see their caretaker dealing with it. I do think that services for the child is imperative, because we know it affects a child from the womb. It affects a child from the womb. So yes, if we're looking at things as a holistic approach and we are really addressing mind, body, spirit, we do need to look at not only the adult but the child as well. Thank you for that question.

>> What are your feelings about doing couple counseling as a means for addressing IPV? Should couple work be put off until there is individual treatment, and if so why? If not, how do you do couples work?

>> BELINDA JAMES: I would not encourage couples counseling when addressing issues of intimate partner violence because of the fact that it's about power and control, and it would be very hard for a healthy atmosphere to be built if you have the abuser and the survivor in the room at the same time, and that practitioner is trying to address those issues. It needs to be individual counseling so that the abuser can address those issues of aggression and anger and maybe hurts from the past, and the survivor in his or her own counseling session can address their hurts from the violence. That would be my recommendation, to keep it very separate, and then after some time of individual therapy, then yes, coming together to do some couples counseling is important but that will help build the relationship and set that healthier foundation of communication.

>> Belinda, do you think that in the individual counseling, if the abuser is knowing that the wife is getting individual counseling, do you think that will cause more conflict in the home and then what should she do with that, if it's bringing more confusion in the home and maybe more violence in the home.

>> BELINDA JAMES: You know, it's an interesting question on whether or not the individual counseling

can become a problem. It certainly can, because if there's a power and control issue, that abuser is concerned that the survivor is going to maybe get more independence, get some help and maybe disconnect themselves from the abuser. So yes, it can definitely be a challenge. However, it is empowering. It is empowering for the survivor to do that for themselves. That's part of the self-care piece. That's part of the healing process, but it is also about timing. So for that survivor they have to know the timing and the dynamics in the relationship to be able to do that. But yes, I encourage it.

>> This may be a teaser for next week. You tell me. How do you as a therapist deal with a client who is experiencing abuse but insists on minimizing the problem?

>> BELINDA JAMES: It's a therapeutic alliance you build with the client so over time once you build that alliance you're also building a safeplace for you as the clinician to gently challenge the client's thinking. So if the client is minimizing the issues over time, as the clinician, do you say, think about this. You do challenge the person to use what's called bifocal vision and see the full picture, of the hurts and the positives, because part of behavioral change is to challenge a client's thinking, and so that's done in a very caring, very safe, therapeutic environment. But yes, it is done.

>> THOM PANCELLA: All right. I think we've done it.

>> BELINDA JAMES: Great. If there are other questions, I certainly encourage those questions to continue to the chat. Send questions to the chat.

>> THOM PANCELLA: And make an email to us as well and tune in next week to make sure as we begin the process of the conversation, that you're able to have your questions addressed as well. So thank you very much for joining us this afternoon. We'll leave the links open for the CEUs and the slides. We'll send them to you in a follow-up email as well so you can purchase CEUs after the fact if you're interested. Be sure and join us next week for Part 2 of this discussion. Encourage your friends and colleagues to join us as well. We had a good crowd on-line today. Thanks to the folks who joined us in the room and especially, Belinda, thank you for your time and your expertise.

>> BELINDA JAMES: Thank you. I appreciate the opportunity.

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