Sex and Gender Analysis of Intimate Partner Violence

Developed in Women, Gender and Health 207:
Advanced Topics of Women, Gender, and Health,
Harvard T.H. Chan School of Public Health, Spring 2015

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Appropriate Harvard T.H. Chan School of Public Health Core Courses:
This teaching example is meant to be used in introductory social and behavioral sciences and social epidemiology courses, such as Social & Behavioral Sciences 201, that explore different levels of interventions (e.g., high risk vs. population) as well as the influence of social determinants of health (e.g., education, income) on population health.

Brief Background:
For many years intimate partner violence (IPV), specifically, abuse of a wife by her husband, was considered a normal and acceptable part of the family dynamic. But in recent years, social advocacy groups and public health professionals have been attempting to measure rates of partner abuse between married and unmarried couples of all genders in order to better inform IPV prevention programs. Partner abuse can be any mistreatment of a partner that reinforces a dynamic of power and control of one partner over the other, including physical violence, verbal harassment, financial abuse, rape and sexual assault, reproductive coercion, and stalking. A 2010 survey conducted by the CDC revealed that more than 1 in 3 women and 1 in 4 men have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). Experiencing abuse or violence from a partner is prevalent across socioeconomic strata and race/ethnicity (Black et al., 2011). Available data on experiences of IPV among lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations shows that approximately 6% of IPV survivors identify as transgender, and that experiences of IPV among sexual minorities was also highly prevalent (Chestnut et al., 2013).

Intimate partner violence and abuse is associated with adverse health outcomes across the lifespan. Violence and abuse can be associated with physical bodily injury, posttraumatic stress disorder, self-harm, complications during pregnancy and chronic illness. The social and psychological consequences of experiencing partner abuse can also impact health. Financial abuse and emotional manipulation by a partner, and resulting social isolation and fiscal dependency, can make it harder

for a person to leave the abusive environment or seek care (CDC, 2015). Given the high prevalence and long-term health consequences of partner abuse and violence, introducing the topic as a public health issue can be a way to educate students about the social determinants of health and discuss strategies for prevention.

Learning Objectives for Students:

1) Apply Geoffrey Rose's concepts of the two strategies of prevention (the high risk and population strategies [Rose, 1985]) to the analysis of intimate partner violence.
2) Prompt students to use gender-based analysis to self-reflect on their own assumptions about who is affected by IPV and how they are affected.
3) Explain the mechanisms and pathways through which social determinants of health, such as income, occupation and social networks, affect health outcomes.

Teaching Methods:

1) **Begin discussion with a trigger warning:** "I/we acknowledge that IPV is a sensitive topic for many people. We are not making any assumptions about your experience with this topic. If at any point you feel you feel uncomfortable and need to step outside for a few minutes, feel free to do so."

2) **Facilitate small-group discussion (Approx. 15 minutes):** Divide students into two groups (one group for each vignette). Distribute handouts with one of the two vignettes and the following prompts to each group:
    - What are some of the pathways/mechanisms through which IPV can impact health?
    - What are the challenges individuals, families, and providers may face in accessing IPV-related social services and legal systems that are already in place?
    - How does gender come into play in this vignette?
        - For example: What is the gender of each individual in your vignette? What cues did you use to decide? How might each individual's gender have influenced their decisions and their access to services? How might it influence possible IPV prevention strategies?
    - What are the opportunities to intervene to address the abusive relationship as a: (a) medical professional, (b) public health professional, or (c) bystander?
    - What are the pros and cons of interventions from different perspectives?

3) **Larger group discussion (Approx. 15-20 minutes):** Instructor should bring the two small groups back together and allow each group time to share their thoughts (10 minutes). The larger group discussion should be facilitated such that the class can take a step back from the

vignettes and talk about IPV as a concept more broadly, using the prompts below:

- What are examples of different interventions on different levels?
- What additional data is needed to design better interventions?
- Where are the opportunities to intervene from the abuser's side? Did any groups consider this originally?
- Vignette-specific notes:
  - Vignette # 1: Facilitator should highlight that the group is talking about two different concepts: J can get pregnant because of her biological sex; however her gender and her partner's gender contribute to their relationship dynamics.
  - Vignette #2: Who was MK? Did we make assumptions about their gender? How can we account for gender diversity when designing IPV interventions?

References:

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS)*: 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Center for Disease Prevention and Control (Updated March 5, 2015). "Intimate Partner Violence: Consequences". Retrieved from: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html.

Chestnut, S., Dixon, E., & Jindasurat, C. (2013). Lesbian, gay, bisexual, transgender, queer, and HIV-affected hate violence in 2012. *NewYork: A report from the National Coalition of Anti-Violence Programs (NCAVP)*.

Rose, G. (1985). "Sick Individuals and Sick Populations." *International Journal of Epidemiology 14*(1): 32–38.

Supplemental Materials: Sample Vignettes

Vignette #1:

HM seemed like JL's dream partner when they first started dating. HM was so romantic, and was always talking about being with JL forever and starting a family. They got married within 6 months of dating, as getting married early was common in their culture. JL had been on the pill for several years, but once she moved in with HM, her pill packs started to go missing. JL asked HM about it, who said, "Why are you asking me? You must have lost them because you're so messy." HM wanted to have sex even when JL had missed pills and JL became pregnant. She hid the pregnancy for several weeks, afraid of losing her job if she was found to be pregnant.

At JL's first OB/GYN appointment, she is screened for and diagnosed with gestational diabetes. Her doctor recommends improving her nutrition and exercising, and schedules follow-up visits. HM says he will support JL however he can, because he loves her and the baby. However, HM insists on keeping his favorite snacks in the house and will not allow JL to spend time exercising, telling her that, "Men will look at you and get ideas if you run around in shorts!" JL misses her follow-up visits as she cannot take time off of work, and the closest OB/GYN clinic takes her over an hour to get to.

Vignette #2:

When MK and AC first started dating, MK would shower AC with extravagant gifts, even when there was no occasion. AC's friends were always impressed with how supportive and loving MK was, and helped the couple move in together. Around the same time, AC's work contract expired but MK persuaded AC to take time off rather than looking for work, saying "Don't worry, I make enough at the firm for both of us." Because MK was now their main source of income, MK signed their name on the paperwork for the apartment, opened up an account for the couple in MK's name and transferred AC's savings into it. MK also gave AC a debit card for "anything you'd like." A few weeks later though, when AC bought a few things for the apartment, MK said that they didn't like wasting money like that, and made AC return the items. Whenever AC voiced the idea of going back to work, MK would retort "You won't have time for me if we both work. Our relationship won't make it."

A few months later, AC is feeling tired and doesn't want to get out of bed in the mornings. Most days, AC also has headaches. When AC voices to MK that they would like to go to the doctor, MK responds "You don't need a doctor – take 2 Tylenol for your headache and drink some coffee in the mornings. I don't want you wasting my health insurance on this." AC is unsure about what to do; MK would know if AC used the health insurance card or debit card. Finally one day, when the headache gets especially bad while out running errands, AC walks into the local hospital's emergency room.