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Health Care Providers' Attitudes Toward Screening Patients for Sexual Violence and Intimate Partner Violence

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By

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DEDICATION

This thesis is dedicated to my sister, Savannah Jane, who is my biggest role model, greatest supporter, best friend, and number one fan. She is one of the most strong and intelligent women I have ever known.

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ABSTRACT

The primary purpose of this quasi-experimental study of health care providers at a faith-based clinic for uninsured adults in a metropolitan area was to determine health care providers' knowledge of and attitudes towards the use of SV and IPV screening tools. This study measured a volunteer group of primary care providers' knowledge and attitudes towards SV and IPV screening tools before and after applying an educational intervention presenting the benefits of screening and identifying patients who have previously been, currently are, or at risk to suffer abuse. A total of 10 eligible participants completed all elements of the study. The pre and posttest contained 4 demographic questions, 18 Likert-scale style questions, and 5 open ended questions.

Participants believed it to be true that abuse has negative physical and mental health effects on its victims; and that they have a role in improving patients physical and mental health. Some participants felt that the use of screening tools could potentially bring patients discomfort or upset, and the most commonly reported barrier to administration of tools was time. After intervention, participants reported in increase in belief that administering screening tools could lead to an increase in identification of victims, and an improvement in patients' mental and physical health. Post intervention, the majority of participants showed a stronger willingness to integrate screening tools into their practice. The study showed that HCPs are interested in learning more about SV and IPV screening tools, but that several barriers to implementation exist. Future research should focus on solutions for the barriers that exist to implementing universal SV and IPV screening tools in the primary care setting.

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LIST OF ABBREVITIONS

SV: Sexual violence

IPV: Intimate partner violence

HCPs: Healthcare providers

CDC: Center for Disease Control and Prevention

NISVS: National Intimate Partner and Sexual Violence Survey

RAINN: Rape, Abuse & Incest National Network

ACEs: Adverse Childhood Experiences

PTSD: Post-traumatic stress disorder

WCSAP: Washington Coalition of Sexual Assault Programs

NCICP: National Center for Injury Prevention and Control

STIs: Sexually transmitted infections

UTIs: Urinary tract infections

COPD: Chronic obstructive pulmonary disease

AIDS: Acquired immunodeficiency syndrome

PAHO: Pan American Health Organization

WHO: World Health Organization

AAFP: American Academy of Family Physicians

ACOG: American College of Obstetricians and Gynecologists

USPTF: United States Preventative Task Force

HRSA: Health Resources and Services Administration

TIC: Trauma-Informed Care

SAMHSA: Substance Abuse and Mental Health Services Administration

NP: Nurse Practitioner

HITS: Hurt, Insult, Threaten, Scream

IRB: Institutional Review Board

COVID-19: Coronavirus disease 2019

Introduction

Sexual violence (SV) and intimate partner violence (IPV) are devastating issues that affect individuals regardless of gender, age, race/ethnicity, sexual orientation, or socioeconomic status. The consequences violence has on victims can be extreme and detrimental. Aside from the pain, discomfort, and traumatization that occurs at the time of assault, victims are likely to experience physical and mental health consequences that may last for months, years, or even a lifetime (Garcia-Moreno et al., 2012). Research has identified vulnerable populations, risk factors of victimization, and how an abuse victim might present in the clinical setting. Still, victims often encounter barriers to receiving care/resources. Failure to screen for IPV, SV leads to failure to identify patients who may benefit from resources. There are numerous screening tools and resources available for healthcare providers (HCPs) to properly identify and intervene with victims of SV and IPV, yet the evidence that HCPs routinely use these tools is low (Alverez et al., 2017; Elliott et al., 2002; Friedman et al., 1992; Littleton et al., 2007). There is a need for further research regarding providers' current knowledge and use of SV and IPV screening tools, and the barriers that exist to using tools routinely during patient visits in the primary care setting. The purpose of this quasi-experimental study of health care providers at a faith-based clinic for uninsured adults in a metropolitan area is to determine health care providers' knowledge and attitudes towards the use of SV and IPV screening tools.

Background

Prevalence of SV and IPV by gender

The Center for Disease Control defines SV as "any sexual activity where consent is not freely given" (CDC, 2021). Statistics of SV and rape among men and women were reported from the data collection of the National Intimate Partner and Sexual Violence Survey (NISVS): 2010. The survey showed that 1 in 5 women and nearly 1 in 71 men have experienced attempted or completed rape in their lifetime. Additionally, nearly 1 in 2 women and 1 in 5 men report experiencing some form of SV other than rape during their lifetime; including being made to penetrate some else, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences (Basile, et al., 2011). According to the CDC, the current rate of SV involving physical contact among women is more than 1 in 3, and among men, nearly 1 in 4 (CDC, 2021). The CDC notes that a high number of these cases go unreported, and therefore these statistics likely underestimate the significance of this problem (CDC, 2021).

IPV and SV are strongly linked. It is likely that an individual who has experienced one of these, has or will experience the other. IPV may lead to SV, and a sexual assault may put an individual at higher risk for ending up in a relationship with a partner who abuses them. IPV is defined as "abuse or aggression that occurs in a close relationship", which can vary in frequency and severity, and includes physical and SV, stalking, and psychological aggression (CDC, 2020). The CDC claims that about 1 in 4 women and 1 in 10 men have suffered from some combination of IPV behaviors from an intimate partner in their lifetime. Also, about 1 in 5 homicide victims are killed by an intimate partner, with over half of all female homicide victims having been

killed by a current or former male intimate partner (CDC, 2020). As with SV, it is likely that these numbers underrepresent the number of cases that actually occur.

Prevalence of SV and IPV by race/ethnicity

The CDC's NISVS of 2010-2012 acknowledges the discrepancies between different races/ethnicities and prevalence of abuse. The survey revealed that multi-racial men and women report more experiences of both SV and IPV than other races and ethnicities, with Asian pacific islander men and women reporting the least. Nearly half of multiracial women (49.5%) and nearly a third of multiracial men (31.9%) report experiencing some form of SV during their life (Smith et al., 2017, p. 20, 26, 27). Also, more than half of multiracial women (56.6%) and 42.3% of multiracial men report experiencing some form of intimate partner contact SV, physical violence, and/or stalking in their lifetime (Smith et al., 2017, p. 121).

Prevalence of SV and IPV by age

The prevalence of SV and IPV varies among age groups, and statistics show young people being at higher risk. Research shows that young adults have a higher risk of experiencing sexual violence than other age groups, with more than half (54%) of victims being between the ages of 18-34 (RAINN, 2021). Similarly, the most likely age for both men and women to experience IPV for the first time is between the ages of 18-24 (Black et al., 2011, p. 49).

Prevalence of SV and IPV by sexual orientation

The NISVS: 2010 Findings on Victimization by Sexual Orientation describes the variances of SV and IPV between lesbian, gay, straight, and bisexual people. The NISVS reports that bisexual women (46.1%) report more occurrences of rape than heterosexual (17.4%) and lesbian women (13.1%). Bisexual women (74.9%) also report more experiences of SV other than rape than lesbian women (46.4%) or heterosexual women (43.3%). Lastly, bisexual women

(61.1%) also report more occurrences of rape, physical violence, and/or stalking by an intimate partner during their life than lesbian women (43.8%), and heterosexual women (35%) (Walters et al., 2013, p 1-2).

The NISVS also includes statistics about men. It is reported that 47.4% of bisexual men, 40.2% of gay men, and 20.8% of heterosexual men experience sexual violence other than rape during their life. Also, 37.3% of bisexual men, 29.0% of heterosexual, and 26.0% of gay men experience rape, physical violence, and/or stalking by an intimate partner during their life. Discrepancies between men's sexual orientation in regard to rape were not reported due to numbers being too small for a reliable estimate (Walters et al., 2013, p 1-2).

SV and poverty

Greco and Dawgert (2007, p. 20) describe the link between poverty and sexual violence. They describe this relationship as complex and cyclical. People living in poverty might be a likely target for perpetrators due to the lack of power poverty can bring. They could have lifestyles that increase their risk of danger since they might be more dependent on other people for survival. It is cyclical because sexual violence can increase the likelihood of becoming homeless, using/abusing substance, and developing mental or physical illness which are all things that can increase the likelihood of victimization or revictimization (Greco & Dawgert, 2007, p. 20).

IPV and socioeconomic class

The National Crime Victims' Rights Week (2017) IPV fact sheet shows statistics of IPV by household income in thousands of victimizations. Although the prevalence was highest among households making between $15,000 and $24,999, IPV was not isolated to any particular income bracket (National Crime Victims' Rights Week, 2017).

Risk factors of SV and IPV

Although it has not been deeply studied, researchers have found some specific risk factors that potentially place an individual at greater risk of experiencing SV or IPV in their lifetime, when compared to an individual without specific risk factors. Select risk factors include demographics, substance abuse, and prior traumatization (child abuse, SV, or IPV). Understanding possible links between personal history and SV or IPV could allow HCPs to better identify at risk patients. Cognizance of risk factors may motivate providers toward universal screening.

Demographics

Research shows that victims of SV and IPV tend to be women more often than men (Basile, Smith, et al., 2014), multi-racial more often than other races and ethnicities (Smith et al., p. 121), younger adults rather than older adults (RAINN, 2021), (Black et al., 2011), bisexual more than gay, lesbian, or straight (Walters et al., 2013), and can be from any income level (National Crime Victims' Rights Week, 2017). There could be a number of reasons for the discrepancies among different demographics regarding abuse prevalence; and although these statistics are important and can help bring awareness to populations who need it most, providers should be careful not to make assumptions based exclusively on demographics alone, as a person of any gender, race, age, or sexual orientation can have a history of victimization, or risk of victimization.

Substance misuse/abuse

Research shows a link between substance misuse/abuse and SV or IPV victimization. Dawgert (2009, p. 21) describes the relationship between SV and substance use, abuse, or addiction as reciprocal, as substance misuse could be a precursor or consequence of SV. There

are different ways that drugs and alcohol might contribute to occurrences of SV including substances being used to facilitate an assault, individuals using or addicted to substances being at a higher risk for experiencing an assault, and victims of assaults using substances as a coping mechanism (potentially leading to revictimization) (Dawgert, 2009, p. 28). A study about the incidence of IPV and substance abuse as co-morbidities suggested that the use of substances may lead to IPV due to altered perceptions and bad decision making. For example, negative social interactions are more likely when both partners are intoxicated. Substance abuse may provoke aggression or lead to deviant behavior resulting in increased likelihood of IPV. Victims may use drugs as a maladaptive coping mechanism, thus making themselves more vulnerable to revictimization (Sabina et al., 2017). The Adverse Childhood Experiences (ACE) study identified a link between a history of ACEs and future substance use, multiple sexual partners and a history of experiencing a sexually transmitted infection (Felitti et al., 1998, p. 249-250).

Childhood abuse

Researchers have found a significant relationship between childhood abuse and SV and/or IPV victimization later in life. In a study titled "Trajectories of Intimate Partner Violence", researchers examined which latent trajectories of females IPV exist by using negative childhood experiences to predict IPV trajectories (Swartout et al., 2012). The study determined that women with a history of childhood physical abuse were more likely to experience frequent and consistent IPV later in life. The study also indicated that a finding of sexual abuse predicted a positive history of having experienced or witnessed childhood trauma or abuse, placing them on a high trajectory for experiencing future IPV (Swartout et al., 2012). A study done on sexual revictimization found that women with a history of childhood sexual assault were twice as likely to experience sexual assault later in life (Van Bruggen et al., 2006).

It is important to note that childhood sexual or physical abuse does not directly cause sexual abuse later in life, but rather potentially causes issues among its victims that predispose them to a higher risk of victimization. Therefore, the sheer history of experiencing childhood abuse is a high-risk factor for later abuse (Swartout et al., 2012). Some issues that put victims of childhood abuse at higher risk for victimization include low self-esteem, fears and anxieties, shame and guilt, trust challenges, feelings of abandonment, and dysfunctional sexual behaviors such as early sexual encounters, and multiple casual sexual partners (Van Bruggen et al., 2006). A study done on adult victims of SV explained that individuals with a history of childhood abuse often but not always experienced post-traumatic stress disorder (PTSD), and that individuals with PTSD are at significantly higher risk of sexual victimization than those without (Xu et al., 2013). Psychological difficulties as a result of abuse may, in and of itself, place the victim at higher risk for IPV due to their increasing vulnerability in relationships (Van Bruggen et al., 2006).

Health consequences of SV

The health consequences of sexual violence can be severe and long-lasting. The Washington Coalition of Sexual Assault Programs (WCSAP) describes potential health effects of sexual assault. Some physical effects may include include injury from assault, somatic complaints, localized pain, and trouble sleeping. Mentally, a victim might experience depression, anxiety, suicidal thoughts, eating disorders, phobias, PTSD, nightmares, and various negative emotional reactions (WCSAP, 2018).

The CDC (2021) explains some behavioral consequences of sexual violence including relationship difficulties, withdrawal/isolation, substance abuse, and engagement in risky sexual behavior. Also, sexual and reproductive effects for women might include vaginal bleeding,

unwanted pregnancy, and sexually transmitted infections. Lastly, SV is linked to other forms of violence, meaning that victims of SV are more likely to experience future SV, as well as IPV in adulthood. (CDC, 2021).

Health consequences of IPV

The health consequences of IPV can be similar to those of sexual violence. The Pan American Health Organization (PAHO) and World Health Organization (WHO) (2012) describes the physical, mental, sexual/reproductive, behavioral, and chronic health effects of IPV. Physical effects include immediate injuries and serious injuries to the head, eyes, ears, chest and abdomen. Mental effects include depression, stress and anxiety disorders, self-harm and suicide attempts, and low self-esteem. Sexual and reproductive effects include unwanted pregnancy, sexually transmitted infections (STIs), miscarriage, vaginal bleeding, urinary tract infections (UTIs), fistulas, painful sexual intercourse and sexual dysfunction. Behavioral consequences include substance abuse, multiple sexual partners, low rates of contraceptive and condom use, and choosing abusive partners later in life. Lastly, long-term or chronic issues of intimate partner violence include poor overall health status, chronic pain, chronic pelvic infection, PTSD, and femicide and acquired immunodeficiency syndrome (AIDS) related death (PAHO & WHO, 2012).

The ACE Study

Although this project is focuses primarily on SV and IPV, the ACE study is a strong correlate that requires further discussion. Felitti et al., (1998) defines adverse childhood events to include experiences of physical, mental, and sexual abuse or neglect, violence in the home or community, having a family member who attempts or dies by suicide, or growing up in a household with substance abuse, mental illness, parental relationship instability. The ACE study

illustrated links between experiencing adverse childhood events and being diagnosed with comorbidities later in life including ischemic heart disease, cancer, stroke, chronic obstructive pulmonary disease (COPD), diabetes, hepatitis, and skeletal fractures, as well as an increase in smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, drug use, number of sexual partners, and history of STIs (Felitti et al., 1998). The link between ACEs appears to revolve around behaviors like smoking, substance abuse, overeating, and sexual behaviors that might have been used as coping mechanisms from the experienced anxiety, anger, and depression that ACEs bring onto a child (Felitti et al., 1998, p. 253).

How a victim of SV or IPV may present in the clinical setting

In addition to knowing risk factors of victimization, being aware of possible behaviors of victims of SV and IPV in the clinical setting could help HCPs in identifying and helping more victims. It is possible that a victim presents similarly as a non-victim in the clinical setting. However, there are select behaviors that victims of SV may exhibit that should raise a red flag for providers. According to Hellman & Clark (n.d.) these behaviors may include delaying seeking medical treatment for injuries, complaints of non-specific symptoms, symptoms of PTSD (increased startle response, hyperarousal), and discomfort with undressing.

Similarly, McCarthy & Bianchi (n.d.) list patient possible behaviors indicative of IPV to include inconsistent explanation of injuries, delay in seeking treatment, frequent emergency department or urgent visits, missed appointments, medication nonadherence, inappropriate affect (jumpy, fearful, crying, flat,), avoid eye contact, act hostile, overly attentive or verbally abusive partner, socially isolated, reluctance to undress or have a genital, rectal, or oral examination, repeated abortions, and in pregnancy: late prenatal care.

Awareness of common behaviors and correlates of SV and IPV are important, but HCPs should not rely simply on patient behavior as an indicator of victimization. HCPs should remember that victim behavior is not always predictable, and a lack of stereotypical behavior does not necessarily correlate with an absence of abuse (Hellman & Clark n.d.).

SV and IPV screening tools in the clinical setting

Current tools available

SV and IPV screening tools are commonly used to identify victims of violence and sometimes the severity of violence. There are several IPV and SV screening tools currently available for use in the clinical setting. The CDC released a publication titled *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings* in 2007. This document outlines 34 screening tools for IPV and 14 screening tools for SV, with some assessments being included in both sections.

The HITS assessment, developed by Sherin, Sinacore, Li, Zitter, and Shakil, is a 4-item self-report or clinician administered tool that assesses the frequency of IPV (Basile, Hertz, et al., 2007 p. 16). The Danger assessment, developed by Campbell, is a self-report of 15 items and assesses a women's potential risk of homicide by a male partner (Basile, Hertz, et al., 2007 p. 14). Developed by Hoff and Rosenbaum, the Victimization Assessment Tool is a 5-item clinician administered screening that assesses physical IPV, SV, suicidal ideation, and risk of hurting others (Basile, Hertz, et al., 2007 p. 86). Although not SV or IPV related, two more valuable assessments are the ACE and resilience tools, which are often administered together. The ACE questionnaire includes 20 questions about various childhood trauma (Felitti et al., 1998). The Resilience questionnaire, developed by Rains and McClinn, is 14 questions and reflects one's ability recover from or cope with from trauma (McClinn & Rains, 2013).

HCPs roles and current recommendations

The American Academy of Family Physicians (AAFP) defines a primary care physician as a specialist who provides definitive, comprehensive, and continuing care to the undifferentiated patient, and that they serve as "the entry point for substantially all of the patient's medical and health care needs - not limited by problem origin, organ system, or diagnosis" (Primary Care, 2020). A non-physician primary care provider, such as a nurse practitioner, physician assistant, etc., should provide "services in collaborative teams in which the ultimate responsibility for the patient resides with the primary care physician" (Primary Care, 2020). By these definitions, HCPs have a significant role in identifying and intervening in support of victims of SV and IPV.

The American College of Obstetricians and Gynecologists (ACOG) recommends that "obstetrician–gynecologists and other women's HCPs should screen all women for a history of sexual assault" (Sexual Assault, 2019). The United States Preventative Task Force (USPTF) currently recommends "clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services" (Recommendation: Intimate Partner Violence, 2018). Also, the Health Resources and Services Administration (HRSA) currently recommends "screening adolescents and women for interpersonal and domestic violence at least annually, and, when needed, providing or referring for initial intervention services" (Women's Preventive Services Guidelines, 2020).

Prevalence of use

The current use of SV and IPV screening tools in the clinical setting has not been largely studied. However, research on this topic is growing. In a 2007 study of adult females (n=945) at a family planning clinic in Texas where universal screening was adopted, 52% of participants

reported never having been screened for SV, nor having be provided with information about SV by an HCP (Littleton et al., 2007, p. 564.e3). This means a majority of women were not screened even when screening was the adopted standard. A study by Friedman et al., (1992) surveyed 164 patients and 27 physicians at private and public primary care sites to determine patient preferences and physician practices regarding inquiry of victimization experiences in the primary care setting. It was found that while most providers believed they could help patients with consequences of physical abuse (81%) and sexual abuse (74%), sexual abuse inquiries were not made at 89% of initial or 85% of annual visits, and physical abuse inquiries were not made at 67% of initial or 60% of annual visits (Friedman et al., 1992, p.1186).

A systematic review by Alverez et al., (2017, p. 488) found that among studies regarding rates of use of IPV screening practices, the rates of routine screening by providers were relatively low (2-50%), with rates of selective screening having been higher (45-85%). Elliott et al., (2002, p. 112), conducted a national survey with 1,103 responses from American physicians regarding their use of domestic violence screening measures, their experience with domestic violence training, and their perceived barriers to IPV screening. It was found that while 80% of respondents reported having had training on issues of domestic violence only 6% of them screened all female patients, and overall, they only screened 2-25% of their female patients for domestic violence (Elliott et al., 2002, p. 112).

Identifying and addressing barriers

One of the most commonly mentioned barriers to screening patients for SV or IPV is time (Sprague et al., 2012, p. 596). Providers might feel that time is too limited to incorporate routine screenings into visits. However, simply including a yes or no question in patients' intake

paperwork like, "Do you feel safe?" could narrow down which patients need screening for violence.

Privacy is another issue. A patient is less likely to report abuse or feeling unsafe if their abuser is accompanying them during the visit (Paterno & Draughon, 2016). However, an overprotective or attentive partner should raise a red flag to providers (Salmon, 2013, p. 23), and efforts should be made to isolate the patient during screening (Paterno & Draughon, 2016). Developing practice policies/procedures that support patient privacy by limiting or excluding others from select clinical areas (e.g., triage, exam room, procedure rooms), provides a framework for practice that promotes patient safety.

Still, it is possible that the patient may not be honest when asked about occurrence of abuse. However, providing patients with education about violence helps normalize the conversation and provides potential victims with access to resources without the need for disclosure (Intimate Partner Violence, 2012).

A provider may worry that inquiring about such topics could be triggering, or that the patient is simply not interested. This is very possible. However, research shows that the majority of women are not bothered or upset about being screened for sexual assault, and that they find information about the physical and emotional effects of unwanted sex and information about victims' resources helpful (Littleton et al., 2007, p. 564.e3).

If the screening process does trigger the patient, it is possible that both the patient and provider are now distracted from the initial reason for the client's visit. One way to limit triggering is for HCPs to normalize the assessment or screening process. HCPs should begin the assessment by stating that screening is done for all patients, not because violence is suspected (Intimate Partner Violence, 2012).

Another important barrier is providers' lack of knowledge about screening tools (Sprague et al., 2012, p. 596). A solution is for a clinic to choose one or two screening tools for implementation and have a quick information session with staff on how to properly use them. Many IPV and SV screening tools are similar to depression and anxiety tools in that they include instructions and interpretation of results and are easy to use.

Providers may believe they have a lack of power in making a difference in violence victimization, but simply providing information and resources in a caring manner may be of tremendous help (Intimate Partner Violence, 2012).

Lastly, providers might be unsure about whether their patient population is even at risk of being victims or suffering from consequences the of violence. However, data indicate that SV and IPV are prominent issues among women and men of all backgrounds, and the potential health effects can be severe enough to impact victims physically, mentally, sexually, and spiritually both short and long-term.

The barriers to screening for SV and IPV in the clinical setting are complex. Research shows that barriers exist on both the patient side and the provider side (Sprague et al., 2012, p. 596). These barriers are complex and valid, and more research is needed to discover and/or develop solutions that enhance patient safety and promote providers' best practice.

Benefits of use

Despite the existing barriers, implementing SV and IPV screening tools in the clinical setting could be beneficial to both patient and provider. Benefits include earlier identification and intervention, prevention of further or future abuse, better utilization of resources, and adhering to best practice standards of care.

Theoretical framework:

The Substance Abuse and Mental Health Administration (SAMHSA) is a leader in supporting the development of trauma-informed care (TIC). SAMHSA (2014, p. 7) defines trauma as a result of an event(s) or circumstances that is experienced by the individual as physical or mentally harmful or life threatening and has lasting consequences on the individuals mental, physical, social, emotional, or spiritual well-being. Over the last few decades, SAMHSA has recognized the need for healthcare professionals to address the way that trauma affects patients and their wellbeing, and how public institutions and service systems may contribute to the resolution or exacerbation of trauma-related issues (re-traumatization) (SAMHSA, 2014, p. 2-3). This need led SAMHSA to the development of TIC principles, grounded in four assumptions (the four "R's") and six key principles. The four "R's" include realization, recognition, response, and resistance of re-traumatization. SAMHSA (2014, p. 9-10) explains that in a trauma-informed system, all people of an organization or system have a realization about trauma and its effects and are able to recognize the signs of trauma. Also, the system responds with principles of trauma-informed approach and seeks to resist re-traumatization of clients and staff. SAMHSA outlines the six key principles: 1.) Safety, 2.) Trustworthiness and Transparency, 3.) Peer Support, 4.) Collaboration Mutuality, 5.) Empowerment, Voice and Choice, and 6.) Cultural, Historical and Gender Issues. To start, safety includes keeping clients and staff physically and psychologically safe. Next, trustworthiness and transparency are used throughout patient care in order to build and maintain trust in all relationships within the system. Additionally, peer support refers to trauma survivors use of their experience(s) to promote recovery and healing. Collaboration and mutuality place an importance on leveling power difference within a system to promote healing through relationships. Empowerment, voice, and