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Sexual Violence and HIV Literature Review

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Literature Review

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Table of Contents

Executive Summary

It has long been recognized that childhood sexual abuse, violence against women, and HIV-risk related behaviours overlap. When examining the interconnections between these, two transmission paths must be considered:

- childhood physical and sexual abuse increasing immediate and future coping behaviours that increase the risk of infection with HIV; and
- intimate partner violence increasing the likelihood of a woman being infected with HIV through a variety of exposures and behaviours.

Childhood sexual abuse occurs when another child, youth or adult engages in sexual activity (with or without penetration) with a child. The rate of substantiated sexual abuse in Canada is approximately 12.8% for females and 4.3% for males. Amongst individuals living with HIV, these rates have been found to be considerably higher; up to 57% in some studies.

HIV risks that are associated with childhood sexual abuse can be separated into two main areas: immediate threat and risk in adulthood. An example of an immediate threat for a child contracting HIV from the perpetrator occurs when the child is injured vaginally or anally during the abuse. Sexual abuse experienced by a child can also lead to behaviours in adulthood that put an individual at risk for HIV transmission. For example, coping behaviours, such as dissociation, alcohol use and self harm may be developed that place the adult at risk. An adult may also experience mental health concerns, including post traumatic stress disorder (PTSD), that lead to at risk behaviours. Lack of sexual health education and information places adults at further risk.

Intimate partner violence refers to sexual, physical, financial, emotional, and spiritual abuse that occurs between two individuals involved in an intimate relationship. The average number of Canadian women who report being in an abusive relationship at any given time is 7%; whereas studies show that for women living with HIV, the percentage of relationship violence is twice this amount (12-14%).

There are several different forms of intimate partner violence that can increase the likelihood of the transmission of HIV. These include sexual violence, physical violence, use of drugs and alcohol, emotional abuse, delayed access to care, inconsistent medical access, difficulty following treatment plans, and isolation.

Literature clearly points to an increased risk of HIV transmission and decreased care by women who have experienced or are experiencing violence in their lives, particularly sexual violence. It is critical that all services that provide medical and social support, treatment and information to women be aware of the interconnections between violence and HIV. Further, it is essential for all professionals to feel comfortable and confident to address both issues with women using their services.

1. Introduction

It has long been recognized that childhood sexual abuse, violence against women, and HIV-risk related behaviours overlap. When examining the interconnections between these, two transmission paths must be considered:

- childhood physical and sexual abuse increasing immediate and future behaviours that increase the risk of infection with HIV; and
- intimate partner violence increasing the likelihood of a woman being infected with HIV through a variety of exposures and behaviours.

The following literature review will explore these areas as well as recommendations to reduce HIV-risk in both areas.

2. Sexual Abuse and HIV

Childhood sexual abuse occurs when another child, youth or adult engages in sexual activity (with or without penetration) with a child. According to the Government of Canada (2006), the rate of sexual abuse in Canada is approximately 12.8% for females and 4.3% for males. It must be noted that many cases of sexual abuse are not reported in childhood and, therefore, would not have been investigated and substantiated (Government of Canada, 2010). Amongst individuals with HIV, these rates have been found to be considerably higher (Gielen, McDonnell, Wu, & O'Campo, 2001; Walton et al., 2011). A recent study in Southern Alberta found that of 853 HIV positive patients, 57% had a history of childhood sexual abuse (Siemieniuk, 2010).

It is important to recognize that sexual abuse often does not occur in isolation. Many times there are other forms of abuse, alcohol and drug use, intimate partner violence, and other dysfunctional family dynamics present. Those who experience multiple maltreatment experiences have been seen to engage in more HIV risk behaviours than those who experience only childhood sexual abuse (Jones et al., 2010).

HIV risks that are associated with childhood sexual abuse can be separated into two main areas: immediate threat and risk in adulthood.

An example of an immediate threat to the child for contracting HIV from the perpetrator is if the child is injured vaginally or anally during the abuse. If the child is exposed to multiple perpetrators, the odds of being infected are increased. An additional threat is lack of access to medical care for the child for fear that the sexual abuse will be discovered.

Sexual abuse experienced by a child can lead to behaviours in adulthood that put an individual at risk for HIV transmission. For example, coping behaviours, such as dissociation, alcohol use and self harm may be developed that place the adult at risk. An adult may experience mental health

concerns, including post traumatic stress disorder (PTSD), that lead to at risk behaviours. Lack of sexual health education and information places adults at further risk.

In a study that looked at the impact of adverse childhood experiences on adult health behaviours and conditions, 13,494 adults received a standardized medical evaluation that examined the relationship between adverse childhood factors (e.g., domestic violence occurring in the child's home) and disease and health behaviours in adulthood. In this study, adverse childhood factors included: recurrent physical abuse; recurrent emotional abuse; contact sexual abuse; an alcoholic and/or drug abuser living in the household; an incarcerated family member; knowing someone who is chronically depressed, mentally ill, institutionalized or suicidal; having a mother who is treated violently; having one or no parent; and experiencing emotional or physical neglect. The study found that the more adverse factors individuals experienced in childhood, the higher the incidence of impacts continuing throughout their life span (Felitti et al., 1998). Adverse childhood factors, including sexual abuse, were linked to increased probability of HIV related sexual risk behaviours (Hills, Anda, Felitti, & Marchbanks, 2001).

2.1 Coping and Health Behaviours in Adulthood that are Associated with Childhood Sexual Abuse

There are several common coping and health behaviours that have been associated with childhood sexual abuse. Many of these increase an individual's risk of HIV transmission, including alcohol and drug use, involvement in the sex trade industry, sexually risky behaviours, self mutilation, a lack of support systems, low self esteem, high levels of self blame, and mental health concerns. Each of these and their risks will be discussed below.

Injection drug use (IDU) is one of the leading risk factors associated with HIV transmission in Saskatchewan (74% of new cases in 2010; Saskatchewan Ministry of Health, 2011). Studies in Europe have shown higher rates of HIV among female injected drug users compared to male (IDU). This may be, in part, because women are more likely than men to share equipment and to have someone else inject them, often using shared equipment (Pinkham & Malinowska-Sempruch, 2008). The Saskatchewan Ministry of Health reported that in 2010 females self-reporting IDU accounted for 4 out of 5 new HIV infections in the 15-19 age group. Many studies have associated childhood sexual abuse with injection drug use (IDU) in adolescence and/or adulthood (Burke et al., 2005; Cohen et al, 2000; Miller & Paone, 1998; Paxton, Myers, Hall & Javenbakht, 2004; Tarashwar, Fox & Ferro, 2005; Wyatt, Myers, & Loeb, 2004). One example of higher rates of sexual abuse being related to injection drug use can be found in the research of El-Bassel, Gilbert, Wu, Go, & Hill (2005). In interviews of 416 women using injection drugs, 54.8% had experienced inappropriate touching or sexual exposure and 23.1% had experienced penetration. This is much higher than the national average, as discussed previously. Studies have also shown the individuals who have been sexually abused and use injection drugs are more likely to start using earlier in their lives than those who have not been sexually abused (Burke et al., 2005; Dube, Felitti, Dong, Chapman, & Giles, 2003; Miller et al., 2002).

Studies have linked alcohol use to delayed access to health care services (Samet et al.,1998), increased medical complications (Cook, et al., 2001; Lucas, Gebo, Chaisson, & Moore, 2002), and decreased compliance with treatment regimes (Samet, et al., 1998). Alcohol use has also been associated with use of drugs, specifically injection drug use (Fuller**,** et al., 2002; O'Malley and Johnson, 2002) and high risk sexual behaviours, e.g., having intercourse without a condom (Grunbaum, et al., 2002).

Research has also shown direct links between childhood sexual abuse and increased risky sexual behaviours, with or without alcohol being involved (Johnson, Cottler, Abdallah, & O'Leary, 2011; Mullings, Marquart, & Brewer, 2000; Tarashwar, Fox & Ferro, 2005). Specific risky behaviours that would increase the risk of HIV include multiple sexual partners, early sexual initiation, and unprotected sexual activities (Arriola, Louden, Doldren, & Fortenberry, 2004; Brown, Kessel, Lourie, Ford & Lispitt, 1997; Felitti et al., 1998; Hills, Anda, Felitti & Marchbanks, 2001; Johnson, Cottler, Abdallah, & O'Leary, 2011; Jones et al., 2010; Maman et al., 2002; Paxton, Myers, Hall, & Javanbakht, 2004; Wyatt, Myers, & Loeb, 2004; Zeihler et al, 2005). These behaviours (along with involvement in the sex trade industry) are associated with a higher likelihood of contracting sexually transmitted infections (Hussey & Singer, 1993; Mosack, Randolph, Dickson-Gomez, Abott, Smith, & Weeks, 2010; Petrak, Bryne, & Baker, 2000; Wilson & Widom, 2009), the presence of which increases the risk of HIV infection.

There is a higher likelihood that women who have experienced sexual abuse will become involved in the sex trade industry compared to those who have not been abused (Arriola, Louden, Doldren, & Fortenberry, 2004; Johnson, Cottler, Abdallah, & O'Leary, 2011; Miller et al., 2002; Mosack, Randolph, Dickson-Gomez, Abott, Smith, & Weeks, 2010; Maman et al., 2002). Studies have indicated that women who work in the sex trade industry and use injection drugs are more likely to participate in other risky behaviours and are less discriminating with their clientele (Pinkham & Malinowska-Sempruch, 2008). Miller et al. (2002) also found that those involved in the sex trade industry who have been sexually abused have more difficulty negotiating safe sexual interactions with clients than those who have not been sexually abused. In addition, there are very few sexual health services available that target the distinct needs of injection drug users and sex trade workers (Pinkham & Malinowska-Sempruch, 2008).

Women who have been sexually abused as children may also use self mutilation as a means of coping (Brodsky, Cloitre, & Dulit, 1995). This includes cutting or burning oneself, and participating in risky sexual activities. Self mutilation as a result of sexual abuse has been linked to higher risk of HIV transmission. One reason for this may be due to the use of unclean (unsanitary) materials used for injuring oneself and the presence of open wounds (Lescano, Brown, Puster, & Miller, 2004).

2.2 Self Blame, Self Esteem and Self Control

Research has shown that childhood sexual abuse can lead to feelings of self blame (the abuse was my fault) and a lack of self control (I will be hurt no matter what I do) and lower self esteem

(I am dirty, worthless) (Paxton, Myers, Hall and Javanbakht, 2004; Ullman & Fillipas, 2006). Self blame can lead to coping behaviours that are risky, as discussed above. Lower levels of self blame in sexual abuse survivors has been associated with less risky coping behaviours, for example, having multiple sexual partners but always using condoms (Peters and Range, 1996). This finding supports the need for programming that helps women to place responsibility for the abuse on the perpetrator.

Lowered levels of self esteem can lead to difficulty caring for self, including problems seeking health information and making informed choices (Paxton, Myers, Hall, and Javanbakht, 2004). This may lead to delayed treatment or an inability to follow through with medical plans. Lowered levels of self esteem associated with sexual abuse can also impact the development of social skills (e.g., communication) and the ability to build a support network (El-Bassel, et al., 2005; Hussey & Singer, 1993; Miller & Paone, 1998).

Several studies looked at individual's feelings of control in a variety of situations, including relationships, sexual acts, initiation into drug use, and social situations. Feeling low levels of control can lead a passive rather than an active role in safety and health behaviours and, therefore, may lead to participation in activities that are high risk for the transmission of HIV (Kinzl & Bieb, 1992; Mosack et al., 2010; Shapiro, Leifer, Martone, & Kassem, 1992).

Childhood sexual abuse also increases the likelihood of being involved in unhealthy adult relationships (El-Bassel, et al., 2005; Johnson, Cottler, Abdallah, & O'Leary, 2011; Jones et al., 2010; Lodico & DiClemente, 1994; Maman, et al., 2002; Wyatt, Myers & Loeb, 2004; Zeirler et al., 2005;). The risks associated with intimate partner violence and HIV transmission will be discussed in the next section. Survivors of sexual abuse are also at high risk for other forms of re-victimization in adulthood, e.g., rape (Arriola, Louden, Doldren, & Fortenberry, 2004; Mosack et al., 2010; Mullings, Marquart & Brewer, 2000; Wyatt, Myers & Loeb, 1997; Zlotnick, Zahrinski, Shea, Costello, Pearlstein, & Simpson, 1996).

Several studies have found that women who have been sexually abused as children have difficulty communicating about sex, sexuality and safe sexual practices (Jones et al., 2010; Kinzl & Bieb, 1992; Lodico & DiClemente, 1994; Mosack et al, 2010; Shapiro, Leifer, Martone & Kassen, 1992; Wyatt, Myers & Loeb, 2004). In part, this may be due to low self esteem, feelings of low control of one's environment, self blame, social difficulties (problems communicating, passiveness, or an inability to trust another person), and/or a lack of sexual health information. Research that examines the intergenerational pathways by which HIV is transmitted has found that a sexually abused woman may be reluctant to share information about sex, and, as a result, her child is potentially more likely to engage in risky behaviours (Cavanaugh & Classen, 2009).

2.3 Mental Health Concerns

Childhood sexual abuse has been associated with several different mental health concerns including posttraumatic stress disorder, anxiety disorders, depression, eating disorders, and personality disorders. Each of these can impact health behaviours.

Posttraumatic stress disorder is caused by experiencing a traumatic event or multiple traumatic events such as sexual abuse (Paxton, Myers, Hall & Javenbakht, 2004). Several of the symptoms of this disorder can lead to higher risks for contracting and transmitting HIV, including:

- Withdrawal from social supports and lower functioning in social situations (Canadian Mental Health Association, 2011; Kinzl & Bieb, 1992; Shapiro, Leifer, Martone, & Kassem, 1992).
- Guilt and self blame (Canadian Mental Health Association, 2011).
- Use of drugs and alcohol (Canadian Mental Health Association, 2011).
- Depression and anxiety (Canadian Mental Health Association, 2011).
- Dissociation/emotional detachment: Dissociation/emotional detachment is a coping skill that allows individuals to detach themselves from the situation that they are in (e.g., feeling like one is watching the abuse occur from outside of the body). When individuals who have used this skill in the past experiences similar or threatening situations, they may unconsciously use this coping skill as it has worked in the past. While beneficial at the time of the abuse, this coping strategy can lead to a lack of control over one's self and one's environment (Canadian Mental Health Association, 2011; Van der kolk et al., 1996; Vander der kolk & Fisher, 1994).

As mentioned, other mental health disorders have also been connected to childhood sexual abuse, e.g., anxiety, depression, eating disorders, and personality disorders. Some of the symptoms of these disorders as well as some ways that women may cope with their symptoms may lead to heightened risk of HIV (Brown, Kessel, Lourie, Ford & Lispitt, 1997; Gielen, McDonnell, Wu, & O'Campo, 2001; Johnson, Cottler, Abdallah, & O'Leary, 2011; Paxton, Myers, Hall, & Javanbakht, 2004; Siemieuniuk, Krentz, Gish & Gill, 2010). Many of these symptoms are the same as have been discussed but can include lowered self esteem, social awkwardness, problems communicating needs with others, self injury, alcohol and drug use, and self blame.

2.4 Recommendations Based on the Link Between Childhood Sexual Abuse and HIV

The following recommendations come from research examining the interconnection between childhood sexual abuse and HIV transmission.

- Screening and intervention for childhood sexual abuse is needed throughout the lifespan (Wilson & Widom, 2009).
- There is a need to address adverse childhood events, including sexual abuse, when dealing with substance use issues. Traditionally, these fields have worked separately and there is a need to work collaboratively (Dube, Felitti, Dong, Chapman & Giles, 2003). Women should be able to access information about all services that may be of benefit to them at their point of entry into the health care or social support system. There is also a need to recognize and

address current adverse events, for example, homelessness and psychological factors related to past trauma (Paxton, Myers, Hall, & Javanbakht, 2004).

- When working with injection drug users (IDU) and/or sex trade workers, there is a need to consider their possible history of sexual violence in order to assist with safe injection strategies and negotiation of safe sex skills (Miller, et al., 2002; Pinkham & Malinowska-Sempruch, 2008). As mentioned previously, feelings of a lack of control in situations and environments as well as low self esteem may impact the use of such strategies. Cognitive behavioural therapy helps women who have experienced childhood sexual abuse to address issues related to affect regulation and sexual communication (Lescano, 2004). Cognitive behavioural therapy helps individuals to determine the links between the way that they think and feel and their behaviours. One example of the effectiveness of this approach can be seen in Peters' and Range's (1996) research. This study showed that helping women to place blame for childhood sexual abuse outside of themselves can allow them to feel that they can have control over current (adult) experiences.
- Both communities and service providers can lower the impact of childhood sexual abuse on HIV high risk behaviours by adopting harm reduction policies and employing strategies that teach sexual and drug risk awareness training. This should include the ability to conduct brief physical and sexual health assessments at multiple points of entry (Johnson, Cottler, Abdallah, & O'Leary, 2011; Pinkham, & Malinowska-Sepruch, 2008).

3. Intimate Partner Violence and HIV

Intimate partner violence refers to sexual, physical, financial, emotional, and spiritual abuse that occurs between two individuals involved in an intimate relationship. Intimate partner violence does not happen in a vacuum. One must consider the social determinants of health when examining this issue. Interconnections of homelessness, poverty, and drug use cannot be ignored.

The average number of women who report being in an abusive relationship at any given time is 7%, whereas for women living with HIV, the percentage of relationship violence was 12.6% (Zierler, Cunningham & Anderson, 2000). However, it is important to note that some studies did not find a significant difference between women abuse in HIV negative and positive populations (Burke, Knab Thieman, Gielen, O'Campo, & McDonnell, 2005; Cohen et al., 2000). Women with HIV report twice as much violence in their relationships as men (Zierler, Cunningham & Anderson, 2000).

As Canada's immigrant community grows, it is important to consider both the rates of HIV and of women abuse in developing countries. In some developing countries, women have one of the fastest growing rates of HIV infection. As well, 10-50% of women globally experience intimate partner violence (Maman et al., 2002). The percentage variance is due to the large number of countries accounted for in this statistic. As discussed in this section, intimate partner violence increases their risk of contracting HIV.

When considering the associations between intimate partner violence and HIV, it is important to look at both the forms of abuse that may lead to an increased risk of transmission of HIV as well as abuse that women experience after being diagnosed as HIV positive.

3.1 Intimate Partner Violence and HIV Transmission Risk

There are several different types of maltreatment that increase the likelihood of the transmission of HIV. These include sexual violence, use of drugs and alcohol, emotional abuse, and isolation.

Sexual violence in intimate partner relationships can increase the likelihood of HIV transmission. Perhaps the most obvious mode of transmission is violent sexual assaults that result in internal injuries (Beadnell, Baker, Morrison, & Knox, 2000; Burke, et al., 2005; Maman, et al., 2002; Molina & Basinait-Smith, 1998).

Sexual violence in relationships is difficult to address for many reasons. First, women may feel that because they are in a relationship or have been sexual with a partner in the past, that they cannot refuse to participate in sexual acts within their relationship (Beadnell, Baker, Morrison, & Knox, 2000; Maman, et al., 2002). Women may feel ashamed, blame themselves and/or feel that they cannot speak about intimate details of their relationship with outsiders and/or their partners. This may limit women's ability to negotiate and use safe sexual practices (Maman, et al., 2002; Molina & Basinait-Smith, 1998).

When one or both people in a relationship have multiple external sexual partners, HIV risk can increase, particularly if strategies are not consistently being used to decrease transmission (Beadnell, Baker, Morrison, & Knox, 2000; Maman, et al., 2002; Molina & Basinait-Smith, 1998). Related to this, intimate partner violence research has shown that between 40-50% of women using shelter services have been infected or re-infected with STIs by their partners who have been non-monogamous (Lichtenstein, 2006; Molina & Basinait-Smith, 1998; Senn, Carey, & Vanable, 2010).

Rates of injection drug use amongst women who are in a relationship that is violent are 25-57%. This is much higher than the national average of 0.2-0.4% of Canadians (men and women not reporting experiencing intimate partner violence) (Canadian Centre on Substance Abuse, 2011). It is important to note that it is difficult to determine whether injection drug use makes women more vulnerable to intimate partner violence or vice versa (El-Bassel, Gilbert, Wu, Go, & Hill, 2005). Women who use injection drugs within the context of an abusive relationship have a heightened risk of using substances prior to sexual activities (Beadnell, Baker, Morrison, & Knox, 2000), have decreased contact with harm reduction programs (Pinkham, Bryne & Baker, 2008) and have increased likelihood to depend on their partner for drugs and equipment (Pinkham, Bryne & Baker, 2008). Other factors which increase risks when using injection drugs have been discussed previously.

One form of intimate partner violence is isolation. Isolation can occur because of actions of the perpetrator but also, due to abuse, the woman may not feel that she deserves care or support (Lichtenstein, 2006). Isolation from friends and family can decrease the amount of support that women have when making health related decisions. Isolation from services can delay both diagnosis and treatment (El-Bassel, et al., 2005).

3.2 Intimate Partner Violence and HIV Diagnosis

Upon diagnosis and disclosure, women may be at an increased risk of violence, e.g., beating or sexual assault (Lichtenstein, 2006; Zierler et al., 2000). Emotional abuse is also common. An example of this is perpetrators threatening to disclose or disclosing the woman's status or lifestyle to friends, family or child protection services (Lichtenstein, 2006). Another common form of abuse is blaming and shaming the woman for/about her diagnosis (Maman et al., 2000) or convincing the woman that she is going to die anyway so there is no need for treatment (Lichtenstein, 2006).

3.3 Intimate Partner Violence and Barriers to HIV Care

Both support and consistent care are critical for effective HIV management and care. In addition to those stated above, the following are barriers to care that can result from being in a violent relationship. Women who are experiencing or have experienced intimate partner violence often delay access to care (Siemieniuk, Krentz, Gish, & Gill, 2010) and when using medical care do not have a consistent health care provider (Lichtenstein, 2006). For example, they may use walk in/urgent care clinics or move between communities frequently. They may also experience an inability to follow through with scheduled appointments for a variety of reasons including not having transportation or child care funding or not being allowed to attend appointments (Lichtenstein, 2006). Secrecy around intimate partner violence may also prevent women from receiving care (Gracia, 2004).

Several researchers have noted other forms of abuse that create barriers to health care, for example, perpetrators not allowing women to access treatment or medication. This includes:

- Destroying HIV medication or using it for their own health care needs (Lichtenstein, 2006)
- Insisting on being treated first for HIV (Lichtenstein, 2006)
- Accompanying the woman to appointments and not allowing her to speak (Lichtenstein, 2006)
- Withholding money and/or wasting money on gambling and drugs or stealing the woman's money which contributes to a lack of financial autonomy (Maman et al., 2010; Lichtenstein, 2006)
- Cutting off methods of transportation, communication or medical care (Lichtenstein, 2006). This can result in missed appointments (Siemieniuk, Krentz, Gish, & Gill, 2010; Beadnell, Baker, Morrison, & Knox, 2000) and therefore inconsistent care.

3.4 Recommendations Related to Intimate Partner Violence and HIV Transmission

The following recommendations have been pulled from research examining the interconnection between intimate partner violence and HIV transmission.

- Ensure intimate partner violence screening occurs in HIV clinics and all medical points of entry (e.g., family doctor, walk in clinic and emergency). For example, WAST (Women Abuse Screening Tool) is a tool that has been studied and found effective in health care settings (Ontario Women Abuse Screening Project, 2011).
- Ensure HIV screening for all women who have a history of intimate partner violence. Have information about HIV testing available at all points of entry, e.g., domestic violence services, food banks, mental health services, and addiction services.
- Provide trainings for health and allied health professionals to increase understanding and sensitivity around both HIV and violence.
- Provide alternate treatment options that allow for confidentiality and safety. For example, pharmacies using cover up labels and women being able to access their medications daily from a clinic, pharmacy or another safe location.
- Bring harm reduction messaging into current information and programming focussing on intimate partner violence (Pinkham, 2008).
- Create women-friendly environments in HIV clinics (Pinkham, 2008).
- Change policies at shelters so that they allow women to have a safe haven when fleeing abuse even if they are using drugs or alcohol (Pinkham, 2008).
- Incorporate HIV programming into services that aren't as obvious so that women can receive care even if their partners are attempting to prevent care (Pinkham, 2008). For example, once a month hold a clinic at an inner city day care or food bank.

The literature clearly points to an increased risk of HIV transmission and decreased care by women who have experienced or are experiencing violence in their lives, particularly sexual violence. It is critical that all services that provide medical and social support, treatment and information to women be aware of the interconnections between violence and HIV. Further, it is essential for all professionals to feel comfortable and confident to address both issues with women using their services.

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