



Healthy Moms, Happy Babies:

A Train the Trainers Curriculum on
Domestic Violence, Reproductive
Coercion and Children Exposed

By Linda Chamberlain, PhD, MPH
and Rebecca Levenson, MA



Formerly Family Violence Prevention Fund

PRODUCED BY

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Frances E. Ashe-Goins, RN, MPH

Acting Director
Office on Women's Health, U.S. DHHS

Aleisha Langhorne, MPH, MHSA

Health Scientist Administrator
Office on Women's Health, U.S. DHHS

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INTRODUCTION

The Affordable Care Act, passed in 2010, included provisions to support America's Healthy Futures Act. This act is a \$1.5 billion dollar, five-year national initiative to support maternal infant and early childhood home visitation programs. In addition to providing funds to support these services, the legislation also included new benchmark requirements for states. One such benchmark requires home visitation programs to measure a reduction in "crime or domestic violence."

This curriculum has been developed to help your home visitation program meet the federal benchmark to address domestic violence.

Futures Without Violence, formerly Family Violence Prevention Fund, has been working with home visitation programs and providing domestic violence training and education for more than a decade. In response to the new federal benchmarks, *Healthy Moms, Happy Babies: A Train the Trainers Curriculum* was created to support state agencies and home visitation programs in developing a core competency strategy and to ensure that all home visitors have training and resources to help women and children living in homes with domestic violence.

The curriculum provides training, tools, and resources to help home visitation staff address the complex and sometimes uncomfortable issue of domestic violence. When it comes to promoting health and safety outcomes for women and children impacted by domestic violence, there is a methodology to effective assessment, primary prevention, and anticipatory guidance messaging during home visits. What one says and how it is said—whether by direct assessment or through universal education—matters and can make a difference for women and children living with domestic violence. First, home visitation professionals need education about the impact of violence on families. They also require tools to support assessment and conversations about domestic violence. This curriculum provides simple tools to support assessment and education through the use of scripts and safety cards during home visits. These tools have been designed to facilitate safety planning and supported referrals to domestic violence programs.

Futures Without Violence is committed to further developing policy and public health responses to domestic violence and reproductive coercion. One of our current initiatives is a multi-state and Indian health initiative called Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women. Since 2010, states and tribes participating in Project Connect have piloted the Healthy Moms, Healthy Babies curriculum and resources. Supported by the Office on Women's Health, U.S. Department of Health and Human Services, Project Connect and the development of this innovative, research-based curriculum has been made possible through funding from the Violence Against Women and the Department of Justice Reauthorization Act of 2005 with additional funding from the Administration for Children and Families. Our hope is that every home visitation program will integrate this curriculum into their core training and programming to support safe and healthy families, and create futures without violence.

Linda Chamberlain, PhD, MPH
Consultant
www.drlindachamberlain.com

Rebecca Levenson, MA
Senior Policy Analyst
Futures Without Violence



Author Biographies

Dr. Linda Chamberlain, an epidemiologist specializing in the health effects of domestic violence on women and children, is the founding director of the Alaska Family Violence Prevention Project and a consultant for Futures Without Violence.

Rebecca Levenson, is Senior Policy Analyst at Futures Without Violence. A nationally recognized speaker, she has worked extensively in the area of reproductive and perinatal health within community clinics and home visitation programs for the past 20 years.

About the National Health Resource Center on Domestic Violence

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking model professional, education and response programs, cutting-edge advocacy and sophisticated technical assistance. The Center offers a wealth of free culturally competent materials that are appropriate for a variety of public and private health professions, settings and departments.

For free technical assistance, and educational materials:

Visit: www.futureswithoutviolence.org/health

Call toll-free (Monday-Friday; 9am-5pm PST):

888-Rx-ABUSE (888-792-2873)

TTY: 800-595-4889

Email: health@futureswithoutviolence.org



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Bibliography

HOW TO USE THIS TRAINERS CURRICULUM

This curriculum has been designed for home visitation programs and is focused on developing staff skills and broadening staff's thinking through interactive exercises and activities.

While this curriculum has been designed so that other trainers can use these resources to conduct training independently, Futures Without Violence staff are available for direct training and technical assistance to model how to use this curriculum and how to develop a plan for sustainability and quality improvement for enhanced domestic violence programming within home visitation and case management programs.

The curriculum includes:

- Overview of how to use the PowerPoint slides, instructions for training, exercises, and directions for small group activities
- Companion CD/DVDs, which include participant handouts, assessment tools, and video clips

For those who have not used PowerPoint previously, as you look at the modules in the curriculum, each page shows both the PowerPoint slide view (top half of the page) and the Notes Page view (bottom half of the page). Speakers' notes for slides are provided in the Notes Page view of PowerPoint. Information provided in the Notes Page view includes: how to facilitate discussion of the data/information reviewed in the slide; how to incorporate the exercises to support participant learning; and guidelines for how to use the tools and handouts during the training.

If you have not used the Notes Page view in PowerPoint before, it can be accessed by selecting the tab called "View" across the top of your computer screen and then selecting the "Notes Page" option. This means that you can access the speakers' notes during your presentation or while you are preparing for a presentation by changing the view on your screen in PowerPoint.

Participants receiving this training should have a basic understanding of domestic violence. However, there is considerable variability among home visitation programs in terms of how much training staff have received. Domestic violence advocates at local shelters and advocacy programs are an excellent resource to contact for domestic violence training and information.

If your audience has not had domestic violence training before or would benefit from a basic overview of domestic violence, then you should include the second module of this presentation: Overview of Domestic Violence: Definitions and Dynamics.

Each topic in this curriculum is a separate module so that you can include all of the content or delete some modules based on the training needs of your audience and the time available for the training.



There are several factors that will influence the length of your training when you use these slides. Factors include:

- Whether you include all of the modules
- If you adjust the time allowed for interactive activities
- How much time you allow for questions and answers
- The amount of local/regional data and information that you add to your presentation

Intended audience:

- This curriculum was designed for home visitors, perinatal case managers, community outreach workers, program managers and agencies that sponsor home visitation programs.

Time needed for training modules:

- If all of the training modules are used, this is an all-day training.
- Consider working with another trainer as a team. Ideally this team would include a domestic violence advocate and a home visitor.
- The curriculum is designed to be flexible. Each module can be used separately so it is possible to do a series of trainings.
- Each module has its own learning objectives. The modules vary in length depending on the topic.
- Modules include discussion questions and/or activities which will influence the length of the training depending on how much time is allowed for these interactive components. While estimated times are provided for discussions and activities, these times could be extended so that the training event is more than one day in length.

Trainer's tip: There are many variables that influence the length of the training including the familiarity of the trainer with the material, the size of the audience, and the time allowed for discussion and activities. Consider doing a practice training with co-workers to become familiar with the content and conduct the activities in this curriculum. We strongly recommend that you keep the interactive activity in place for optimal adult learning.

Materials needed to conduct training:

(Many of these resources may be downloaded at www.FuturesWithoutViolence.org or ordered from our online catalog for a small shipping and handling fee.)

- Trainer's Curriculum and PowerPoint slides
 - DVD: Addressing Domestic Violence In Home Visitation Programs: A Video Training Series
 - DVD: First Impressions
 - DVD: Something My Father Would Do
- "Healthy Moms, Happy Babies" Safety Cards (available at www.FuturesWithoutViolence.org)
- "Loving Parents, Loving Kids" Safety Cards (available at www.FuturesWithoutViolence.org)
- PowerPoint set-up: laptop with DVD player or laptop and external DVD player, LCD projector, screen to project image onto, power cords, and extension cords if needed

- External speakers for playing DVDs (this is very important to have so that your audience can hear the content of the video clips and DVDs)
- Flip-chart with stand and markers
- Masking tape to tape completed flip-chart sheets around the room
- Copies of handouts including the Pre- and Post-training Surveys and PowerPoint slides (select the option for “handouts” and “slides per page: 6” as the options under “print what” when printing your PowerPoint handouts)
- All participants should have a pen or pencil and a few sheets of note paper

Technical Skills for Trainers:

If trainers are not already comfortable using PowerPoint, trainers will need to become familiar and comfortable with this in order to provide training. A copy of the PowerPoint presentation can be downloaded at www.FuturesWithoutViolence.org. It is always important to be prepared for possible equipment issues such as getting your computer to mesh with a LCD projector so test the equipment ahead of time. Also, consider having a back-up projector and/or an extra bulb for the projector available during the training.

Trainer’s Tip: Review the notes before the training and add tabs or markers for information in the notes that you want to highlight during the training.

How This Trainer’s Curriculum is Organized:

Each training module comprises a separate section in this guide which includes:

- Estimated time
- Learning objectives
- Training outline (description of each slide)
- Overview
- Instructions for exercises and activities
- References for studies (in alphabetical order by author’s last name by module)
- Resources

Important notes for Trainers:

- Due to the high prevalence of domestic violence and reproductive coercion among women in the general population, many participants may have had direct or indirect experiences with abuse.
- This type of training can trigger painful memories and feelings for participants. Talking about domestic violence, reproductive coercion, and the effects of violence on children are sensitive topics that can be emotional regardless of whether a person has had any direct experiences with abuse.
- Invite domestic violence advocates from your local/regional domestic violence program/shelter to participate in the training. They can provide the latest information on resources, contact information, and invaluable insights into the topics being discussed. Including

domestic violence advocates in your training can help to build partnerships between home visitors and local domestic violence service providers.

- It is also advisable, whenever possible, to have a domestic violence advocate available during this type of training to talk to any participants who need additional support. If this is not possible, have the number of a local/regional DV program available during the training.
- Remember to be watchful of participants' reactions to the content of this training. Check-in during breaks with any participant that you think may be having difficulties during the training. Give extra breaks as needed, consider turning the lights down if someone is struggling with emotions, give participants an opportunity to debrief, and incorporate breathing and stretching exercises to reduce stress.

Training Site:

- Visit the location for the training ahead of time to determine equipment needs and considerations such as where the projector and laptop will be located, tables/carts for the projector and laptop, if extension cords are needed and what type, where the screen will go, etc.
- Whenever possible, round-tables are recommended versus traditional classroom seating to facilitate group work and discussion.
- Assess parking options, places to eat if lunch is not provided, and any information that you need to share with participants prior to the training.
- Provide refreshments if possible.

Trainer's Tip: To find more information about a study that has been referenced in a slide, go to www.ncbi.nlm.nih.gov/pubmed/ or use a search engine for the term "pub med". Once you are in Pub Med, you can enter the author's name and a word or two from the title of the publication to obtain a listing of publications for that author. Once you have identified the publication you are looking for, you can click on that title to access and print an abstract for that article at no cost. If you want to purchase the article, that information is often provided. Journal publications can also be accessed and copied at medical and university libraries.

LEARNING OBJECTIVES

As a result of this training, home visitors will:

- 1.** Become more aware of the effects of domestic violence on women, children, and families.
- 2.** Explain how domestic violence can interfere with the goals of home visitation programs.
- 3.** Describe the role of the home visitor in assisting with safety planning and providing supported referrals to domestic violence programs for clients who are experiencing domestic violence.
- 4.** Identify strategies to integrate self-assessment tools into routine screening for domestic violence during home visits.
- 5.** Demonstrate how to use safety cards to facilitate safety planning with families experiencing domestic violence.
- 6.** Recognize the role of reproductive coercion in unintended pregnancies and rapid, repeat pregnancies and its impact on the goals of home visitation services.
- 7.** Describe how lifetime exposure to violence can affect parenting and the resiliency of mothers who experience victimization.
- 8.** Become more comfortable with identifying and addressing domestic violence and reproductive coercion with families.
- 9.** Demonstrate competency in educating parents about how their childhood experiences of victimization can be triggered or re-experienced and where to turn for help and support.
- 10.** Increase personal safety and self-care strategies to reduce the potential danger and stress of working with families experiencing domestic violence.

Please note that each training module begins with learning objectives that are also included at the start of each training module in this curriculum.

Sample Agenda for One-Day Training Using All Modules

8:15-8:40 am	Introduction, Workshop Guidelines, and Pre-Training Survey
8:40-9:10 am	Overview of Domestic Violence: Definitions and Dynamics*
9:10-10:25 am	Assessment and Safety Planning for Domestic Violence in Home Visitation
10:25-10:40 am	BREAK
10:40-11:00 am	Impact of Domestic Violence on Perinatal Health Outcomes
11:00-12:05 pm	Making the Connection: Domestic and Sexual Violence, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
12:05-1:00 pm	LUNCH
1:00-1:45 pm	The Effects of Domestic Violence on Children
1:45-2:15 pm	Impact of Domestic Violence on Mothering: Helping Moms Promote Resiliency for Children
2:15-3:00 pm	Childhood Exposure to Domestic Violence and Its Impact on Parenting
3:00-3:10 pm	BREAK
3:10-3:40 pm	Fathering After Violence**
3:40-4:00 pm	Preparing Your Program and Supporting Staff Exposed to Violence and Trauma
4:00-4:20 pm	Mandated Reporting for Child Abuse: Challenges and Considerations
4:20-4:30 pm	Closing and Post-Training Survey

* This is an optional module and the length varies significantly depending on the activities you include

** This is also an optional module, and if you decide not to cover this section, you can add more time for discussion in other sessions

Module 1: Introduction and Workshop Guidelines



Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed

Module 1: Introduction and Workshop Guidelines



Module 1

Estimated Module Time: 25 minutes

Training Outline

- Workshop guidelines
- Pre-training survey
- Review the importance of addressing domestic violence (DV) in home visitation programs
- Next steps to get started

Overview

The purpose of this module is to help the learner understand how screening for DV or intimate partner violence (IPV) can make a difference in the lives of women and children. The module makes the case for home visitors—showing how DV is connected to many other home visitation program outcome goals, and most importantly, demonstrates how talking with health care providers and home visitors increases the likelihood that women are safer and more likely to seek domestic violence advocacy services.



Because family violence is so prevalent, assume that there are survivors among us.

- Be aware of your reactions and take care of yourself first
- Respect confidentiality



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Kennedy Family Violence Prevention Fund

Notes to Trainer: It is very helpful to have a domestic violence advocate present or on call when you are doing a training on domestic violence. This type of training can trigger painful memories while also creating the opportunity for survivors to process their feelings and experiences.

Encourage participants to do what they need to feel safe and comfortable throughout the training such as leaving the room and taking unscheduled breaks. They may also approach one of the trainers at breaks or lunch to talk about issues. As a trainer, you should anticipate that survivors will come forward and want to talk to you, or an advocate for support.

Remain aware of anyone who may be reacting to or be affected by the content of the training. A good example of this is the DVD, *First Impressions*, which is used in the module on “The Effects of Domestic Violence on Children,” which sometimes brings up strong emotions. Consider giving extra breaks after particularly sensitive material, or when you observe that someone is having a difficult time. Connect with that person during the break to check-in and ask if he or she would like to talk with someone and determine how follow-up can occur.





Please complete the
Pre-Training Survey



Module 1

Estimated Activity Time: 5 minutes

Hand-out the pre-training survey for participants to complete and advise them that they will be asked to do a post-training survey at the end of the training. Allow approximately five minutes for participants to complete the survey. Advise participants that they do not need to put their names on the surveys and that their responses are confidential.

“Where
Am I?”



Draw a “comfort meter”

On the left end of the meter is
“not at all comfortable”

On the right end of the meter is
“very comfortable”

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Estimated Activity Time: 2-3 minutes

Ask participants to follow the directions below. Advise them that they do not have to share what they draw/write.

1. Take out a sheet of paper and draw a line with the words “not at all comfortable” on the far left side of their line and the words “very comfortable” on the far right side of their line.
2. Ask participants to take a minute to think about their comfort level right now with talking to clients about domestic violence—and if he or she feels comfortable asking questions and getting a “yes” as the answer.
3. Discuss how the goal at the end of today’s session is that each person has personally moved that needle towards the ‘totally comfortable’ end of the scale.
4. Advise participants that this exercise will be repeated at the end of today’s session and that you will ask them to consider whether the needle moved as a result of the training, where it moved, and their thinking about this in the context of what they have learned.

The “**Where Am I?**” exercise is followed by small group discussion (see next slide) to help participants identify and share why it is important for home visitors to know about domestic violence.



Why is it important for home visitors to know about domestic violence?



Estimated Activity Time: 10 minutes

1. Ask participants to discuss this question for five minutes, breaking up into small groups, if feasible. Instruct groups to prepare a brief answer, consisting of two sentences.
2. Ask each group to share their answers.
3. Go to the next slide which describes how domestic violence is connected to the goals of many programs that provide home visitation services.

Domestic
Violence
Negatively
Impacts
Home
Visitation
Program
Outcomes
Including

- Maternal health
- Pregnancy outcomes
- Children's cognitive and emotional development and physical health
- Parenting skills
- Family safety
- Social support

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Notes to Trainer: These are common goals among many home visitation programs. There is an extensive body of research that has shown how domestic violence is connected to each of these outcomes. These connections will be described in this training.

Women
Who Talked
to Their
Health Care
Provider
About the
Abuse Were

4 times more likely
to use an intervention

2.6 times more likely
to exit the abusive relationship

(McClosky et al. 2006)



Module 1

Notes to Trainer: This section closes with a review of the research that has shown that just having the opportunity to talk to a home visitor or health care provider about domestic violence can increase access to domestic violence services. Examples are also provided for home visitation programs that have had significant impact on domestic violence.

In this study by McCloskey et al. (2006), 132 women outpatients who disclosed domestic violence in the preceding year were recruited from multiple hospital departments and community agencies. Abused women who talked with their health care providers about the abuse were more likely to use an intervention and exit the abusive relationship. Women who were no longer with their abuser reported better physical health than women who stayed.

McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M. Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health. *Public Health Reporter*. 2006;121(4):435-444.

Promising Practice: The Nurse Family Partnership (NFP)



(Olds, Robinson, et al. 2004)

- Randomized, controlled trial
- First-time pregnant women received home visits by paraprofessionals or nurses during pregnancy and during the first 2 years of their child's life
- Two years after the program ended, nurse-visited women reported less domestic violence compared to women in the control group



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The study population was primarily unmarried Mexican American and white pregnant women.

At the time of this study, domestic violence was not routinely assessed or addressed as part of the Nurse Family Partnership (NFP) home visitation model.

It is important to note that NFP has an excellent protocol for dealing with abuse when it comes up and routinely asks about DV at visit one. However, NFP does not routinely ask at other points during visitation. NFP does ask nurse home visitors to inquire further if they see signs.

Olds DL, Robinson J, Pettitt L, Luckey DW, Holmberg J, Ng RK, Isacks K, Sheff K, Henderson CR. Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-up Results of a Randomized Trial. *Pediatrics*. 2004;114(6):1560-1568.



The effectiveness of home visitation services in preventing child abuse is diminished and may even disappear when mothers are being victimized by an intimate partner.

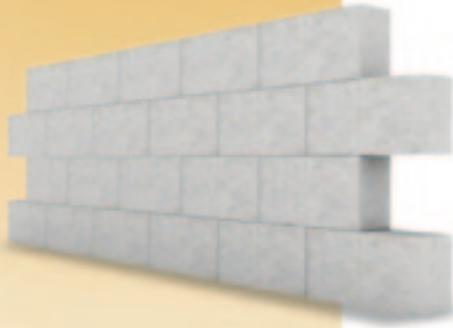
(Eckenrode, et al. 2000)



In a 15-year follow-up of the Nurse Family Partnership model, a home visitation program that has been shown to reduce child maltreatment, the treatment effect of home visits on reducing verified child abuse maltreatment reports decreased as the frequency of DV increased.

Eckenrode J, Ganzel B, Henderson C, Smith E, Olds D, Powers J, Cole R, Kitzman H, Sidora K. (2000) Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence. *Journal of the American Medical Association*. 284(11): 1385-1391.

Barriers to Identifying and Addressing Domestic Violence



(Eddy et al, 2008)

Home visitors identified the following barriers during the implementation phase of a perinatal home visitation program to reduce domestic violence (DV):

- Comfort levels with initiating conversations with clients about DV
- Feelings of frustration and stress when working with clients experiencing DV
- Concerns about personal safety when working in homes where DV may escalate

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Notes to Trainer: This Train the Trainer curriculum is designed to address the barriers uncovered in this study.

These barriers were identified during the implementation of the DOVE project which is described as a promising practice in this chapter. Described as a “Town and Gown” partnership, a university partnered with home visitation programs in several counties. The home visitors who participated in the qualitative study about barriers and facilitators to addressing DV during home visits were a combination of nurses, social workers, and unlicensed home visitors.

Eddy T, Kilburn E, Chang C, Bullock L, Sharps P. Facilitators and Barriers for Implementing Home Visit Interventions to Address Intimate Partner Violence: Town and Gown Partnerships. *Nursing Clinics of North America*. 2008;43:419-435.



- **DOVE: Domestic Violence Enhanced Home Visitation Program**
- **Brochure-based, empowerment intervention delivered by public health nurses to reduce domestic violence among pregnant and post-partum women**
- **Randomized controlled trial in urban and rural settings**

(Eddy et al, 2008)



The brochure-based, empowerment intervention described in the Eddy study is modeled after the empowerment intervention by McFarlane & Parker (1994) which was developed from the Dutton (1992) empowerment model. McFarlane and Parker have evaluated this brief intervention, which allows a woman to share her story and provides information on the cycle of violence, community resources, and safety planning in several studies including an 18-month clinical trial (McFarlane et al, 2002, 2004; Parker et al, 1999). The empowerment model, which takes approximately 20 minutes, is also featured in the “March of Dimes’ Protocol for Prevention and Intervention, 3rd Edition” (2007).

For more information about the DOVE program, contact Phyllis Sharps at psharps@son.jhmi.edu

Dutton M. Empowering and Healing the Battered Woman. 1992. Springer, New York, NY

Eddy T, Kilburn E, Chang C, Bullock L, Sharps P. Facilitators and Barriers for Implementing Home Visit Interventions to Address Intimate Partner Violence: Town and Gown Partnerships. *Nursing Clinics of North America*. 2008;43:419-435.

March of Dimes. Abuse During Pregnancy: A Protocol for Prevention and Intervention, 3rd Edition. 2007. White Plains, NY. www.marchofdimes.com/nursing

McFarlane J, Malecha A, Gist J, Watson K, Batten E, Hall I, Smith S. An intervention to increase safety behaviors of abused women: results of a randomized clinical trial. *Nursing Research*. 2002;51:347-354.

McFarlane J, Malecha A, Gist J, Watson K, Batten E, Hall I, Smith S. A nursing intervention to increase safety behaviors of abused women that remains effective for 18 months. *American Journal of Nursing*. 2004;104(3):40-50.

Parker B, McFarlane J, Soeken K, Sliva C, Reel S. Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing and Health*. 1999;22:59-66.

- DV can reduce the effectiveness of home visitation services
- Home visitors have a unique opportunity to observe clients' home life and relationship dynamics
- Home visitors have contact with women and children in violent households who may not be allowed to access other service providers

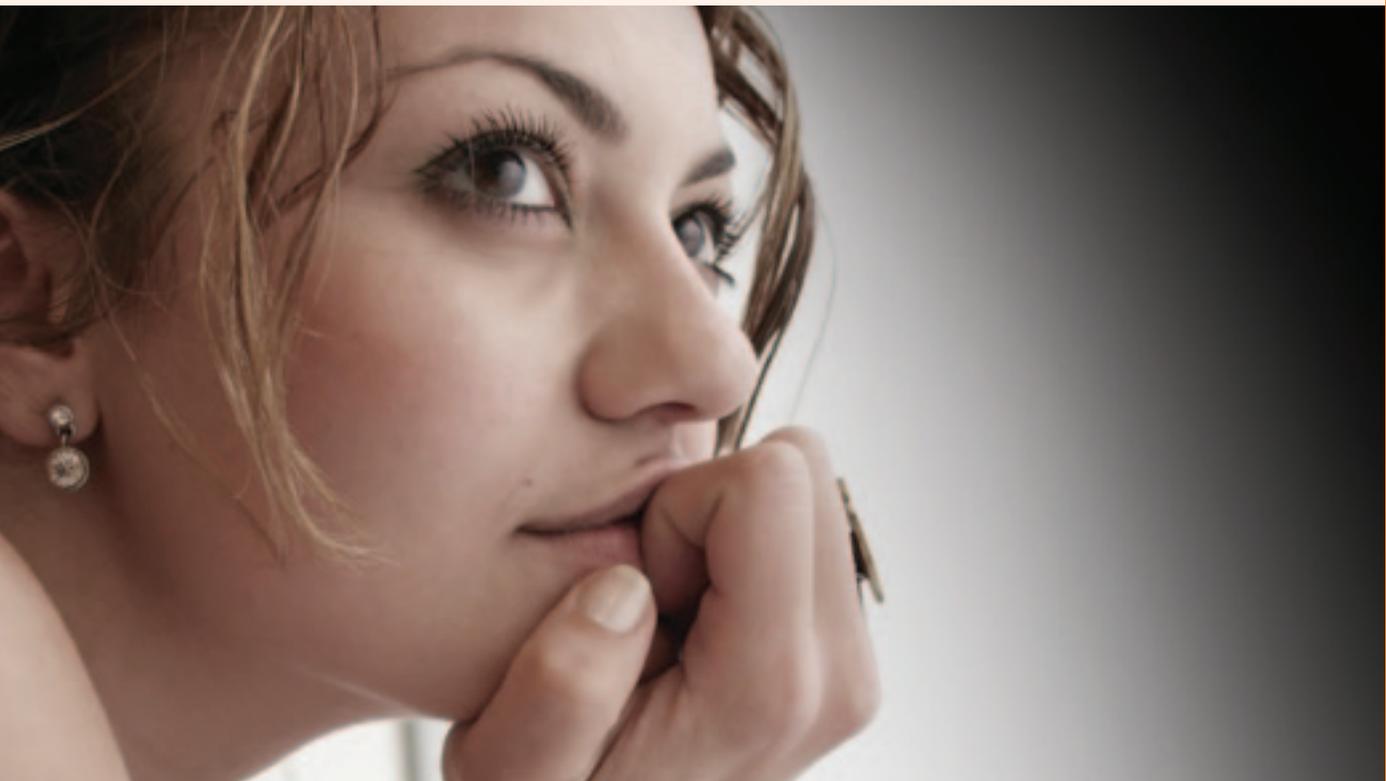
Notes to Trainer: You may want to read the next sentence aloud.

Home visitors may observe a wide range of environmental clues indicating that domestic violence may be present including damaged furniture, doors, and/or walls; high levels of tension in the home; rigid family roles; mistrust of outsiders; high levels of anxiety exhibited by the mother and/or children; and violent acting-out by children.

Evanson, T. (2006). Addressing Domestic Violence Through Maternal-Child Health Home Visiting: What We Do and Do Not Know . *Journal of Community Health Nursing* 23:2, 95-111

Landenburger, Campbell, & Rodriquez. 2004 [Textbook: Family Violence and Nursing Practice, J. Humphreys & J. Campbell, Eds]





Module 2: Overview of Domestic Violence: Definitions and Dynamics



Overview Of Domestic Violence: Definitions and Dynamics



Module 2

Estimated Module Time: 30 minutes (Depending on the amount of discussion time and activities)

This module is recommended if your audience has not had previous training on domestic violence or would benefit from an overview of introductory content on domestic violence. Recommend that participants contact their local domestic violence advocates for more in-depth, comprehensive training on domestic violence.

Training Outline

- Learning objectives
- Magnitude of problem, definitions, and key concepts
- Culture and domestic violence
- Validation and supportive messages

Overview

The module begins with statistics about how common domestic violence is. This is followed by several key definitions and a handout of the Power and Control Wheel to help participants recognize the many different forms of abuse that can occur within intimate relationships.

Learning Objectives

- 1** Describe the prevalence of domestic violence.
- 2** List two examples of power and control in an abusive relationship.
- 3** Discuss two reasons why a woman may stay in an abusive relationship after violence has occurred.



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Notes to Trainer: Read the learning objectives aloud.



1 in 4

(25%) U.S. women
and

1 in 5

(20%) U.S. teen girls report
ever experiencing physical
and/or sexual partner violence



(CDC Morbidity and Mortality Weekly Report,
February 2008; Silverman et al, 2001)



Due to how common domestic violence is, an estimated 15.5 million children live in households where domestic violence has occurred within the past year.

Black MC, Breiding MJ, National Center for Injury Prevention and Control, CDC. Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence---United States, 2005. MMWR. 2008;57(05):113-117.

Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. JAMA. 2001;286(5):572-579.

14% to 52%
of home visited
perinatal clients
experienced
domestic violence
in the past year

(Sharps et al. 2008)

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Sharps and colleagues identified eight studies that assessed DV and used home visitation during the perinatal period. All of the studies are described in a detailed table in the publication by Sharps et al. (2008).

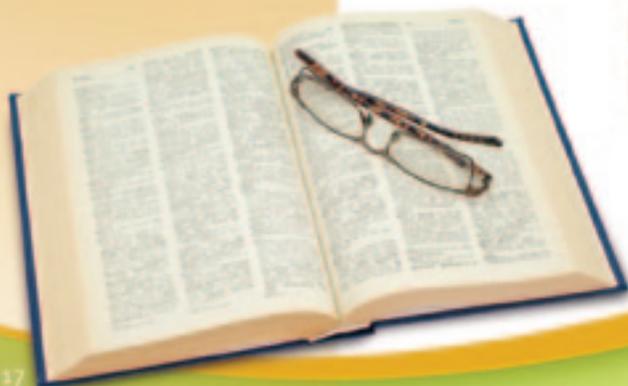
The considerable variation in estimates of prevalence among home-visited perinatal clients is influenced by many factors including whether assessment was routinely implemented, how often the questions were asked, what type of questions/assessment tool was used and how the questions were asked, whether home visitors received training on screening and their comfort level with screening, and differences in the study populations.

Sharps PW, Campbell J, Baty ML, Walker KS, Bair MH. Merritt Current Evidence on Perinatal Home Visiting and Intimate Partner Violence. *J Obstet Gynecol Neonatal Nurs*. 2008; 37 (4): 480-491.



- Legal definitions are often more narrowly defined with particular focus on physical and sexual assault
- Public health definitions include a broader range of controlling behaviors that impact health including:

emotional abuse, social isolation, stalking, intimidation and threats



Notes to Trainer: Advise participants that a definition of reproductive coercion will be provided during this presentation.

**Patterns of coercive
and controlling
behaviors** perpetrated
by an adult or teen against
an intimate partner.



(National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. San Francisco, CA: Family Violence Prevention Fund)



Notes to Trainer: This is the definition of domestic violence.



Why might a woman stay in a relationship when domestic violence has occurred?



Estimated Activity Time: 2 minutes (a quick question and answer for the audience)

Notes to Trainer: Remind the audience that we are focusing on teens and adults who are experiencing abusive behaviors that are perpetrated by their intimate partners. There would be other reasons and circumstances if we were talking about children who were being physically or sexually abused by a parent or another adult.

Reasons why women stay:

- Because she loves him and has hope that he will change
- Lack of safe option for herself and children
- Lack of family or community support/Lack of money or loss of status
- Women do leave—but leaving is a process
- In some cases, the violence does end

Power and Control Wheel

Domestic and dating violence are

NOT

just physical or sexual assault!



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Notes to Trainer: Provide the Power and Control Wheel handout and allow participants a moment or two to review the handout.

For more information on the Wheel go to: www.theduluthmodel.org

A handout on the Power and Control Wheel is available in Appendix B

Domestic violence cuts across all races, ethnicities, religions, sexual orientation, age groups, and socioeconomic levels



- Every culture has elements that *condone* domestic violence...
- and elements that *resist* it



Notes to Trainer: Every culture has elements that condone men's controlling behavior of women and some line differentiating what level of abuse is considered acceptable. For example, under certain circumstances, minor violence such as pushing or shoving might be condoned, while abuse beyond that level is considered unacceptable.

Shelter from the Storm, a curriculum for mental health clinicians who work with children exposed to domestic violence, raises the point that ethnic/cultural background may influence any of the following factors when domestic violence is present:

- The batterer's tactics
- The survivor's coping strategies
- Community response
- Institutional response
- The individual meaning of violence
- The quality of the service provider-client relationships

Anyone can be a victim of domestic violence regardless of: age, race, ethnicity, sexual orientation, religion, class, immigration status, disability, region (rural/urban).

Some studies show that African American, Native American, and Latina women experience higher rates of domestic violence while others find that when socioeconomic status is accounted for ethnic differences are reduced or eliminated.

Mitchell SJ, See HM, Tarkow AKH, Cabrera N. Conducting Studies with Fathers: Challenges and Opportunities Applied Development Science 2007, Vol. 11, No. 4, 239-244.

Tjaden P, Thoennes N. Extent, Nature, and Consequences of Intimate Partner Violence. U.S. Department of Justice, Offices of Justice Programs, National Institute of Justice. Washington, DC. July, 2000.



Cultural Competency Definitions:

Case Study Handout and Discussion

22



Estimated Activity Time: 10 minutes

Notes to Trainer: Distribute the case study on cultural competency and ask participants to read the definitions and scenario (provide a few minutes to do this). Ask the group the following questions:

Question #1: Focusing on cultural and linguistic competency, what concerns do you have about how the home visitor responded to this client's concerns?

Concerns about using the client's husband to interpret should be noted by participants. While the male is usually the head of the household in Dominican culture and is often consulted about health-related decisions, in this situation, the sensitivity of the client's problem would indicate that using her husband as the interpreter is not appropriate. There may also be religious considerations that may be a barrier to the client asking the husband to use condoms.

The client's concern that her husband would be angry raises significant concerns about domestic violence and/or reproductive coercion. Using the client's husband or any family member as an interpreter could be dangerous. The husband may retaliate against the client. Other family members may not keep the information confidential or may confront the husband which could lead to retaliation against the client.

Question #2: What would be a safer approach for this client?

Use a trained interpreter (in-person or by phone) who understands Dominican culture, language, and domestic violence to discuss the following concerns with the client:

- Ask the client if she is being hurt or threatened by her partner and if her partner is interfering with her ability to make choices about her reproductive health, such as using condoms.
- Discuss with the client what may be the safest option to notify her husband that he needs treatment for the sexually transmitted infection.
- Provide information about sexually transmitted infections and treatment and a safety card that addresses domestic violence with hotline phone numbers and local resources in Spanish for the client to review and keep if it is safe for her to do so.





Given the prevalence and complexity of domestic violence —what is the role of the home visitor?



Estimated Activity Time: 2 minutes

Notes to Trainer: Key points to cover in group discussion:

- Goal is not to get her to leave (can be the most dangerous time for her)
- Identify the problem and support her by offering harm reduction strategies
- Connect her to an advocate for safety planning

Module 3: Assessment and Safety Planning for Domestic Violence in Home Visitation



Assessment and Safety Planning for Domestic Violence in Home Visitation



Module 3

Module Time: 1 hour 15 minutes

Training Outline

- Learning objectives
- Group discussion exercise
- Scripted assessment
- Using the *Healthy Moms, Happy Babies* Safety Card
- Using the Relationship Assessment Tool
- Partnering with local domestic violence programs and advocates
- Safety planning characteristics and defining success
- Resources

Overview

Many home visitation programs struggle with domestic violence screening, referral and with building partnerships with local domestic violence programs. Assessment strategies and tools have been developed to integrate screening for domestic violence more comfortably into home visitation programs. The new federal benchmarks for home visitation require that programs document screening, and track referrals. This module will train home visitors how to screen, refer and document these activities as part of routine programming.

Learning Objectives

- 1** Identify two barriers to home visitors doing domestic violence assessment with clients.
- 2** Demonstrate how to discuss limits of confidentiality prior to screening clients for domestic violence.
- 3** Describe how to use the safety card and the “Relationship Assessment Tool” to screen clients for domestic violence.
- 4** List action steps in a safety plan that a client can take if she feels unsafe.

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Notes to Trainer: Read the learning objectives aloud.

- Starting and ending conversations about difficult or stigmatizing issues like domestic violence can be challenging during home visits.
- We take care of ourselves by presenting questions and educational messages in a way that feels most comfortable to us.



Estimated Activity Time: 5 minutes

Notes to Trainer: Ask participants to take the first statement and just think about it for a minute. Each person should take a second and ask themselves if this was ever true for you—or true for a colleague?

Ask participants: “When doing an assessment with one of your clients and working with standardized forms you have to fill out, have you ever not asked a question the way it was written on the form, or changed the order in which the question appeared?” Ask participants to raise their hands if they think it is a safe environment to share their thoughts. If they are worried about getting in trouble with their supervisor they may remain silent.”

Question to pose to the audience: “Do you think this kind of deviation is a good or bad thing?” Then ask about why participants (hypothetically if need be) might deviate from a form—bringing it back to the statements on the slide.

Now let’s look at the second statement—do you think this is true?

Consider
These
Quotes from
Home
Visitation
Staff

- 1 “No one is hurting you, right?”
- 2 “You aren't being abused, are you?”
- 3 “Have you been experiencing any domestic violence?”
- 4 “Are you being abused by your partner?”
- 5 “Are you safe in your home?”



Estimated Activity Time: 5-10 minutes

Notes to Trainer: Taking the first statement, ask participants: What do you think? Does it work? Why do you think they asked this way?

Answer: This assures that clients are clear that the home visitor is looking for a negative answer (same is true of the second question, yes?).

A home visitor could ask any of the questions 1-5—asking any of them as they are would allow someone to check their list that the DV screening or assessment was completed, but it may not effectively identify women in violent relationships.

Discuss question 3 and 4. What are the problems with these questions?

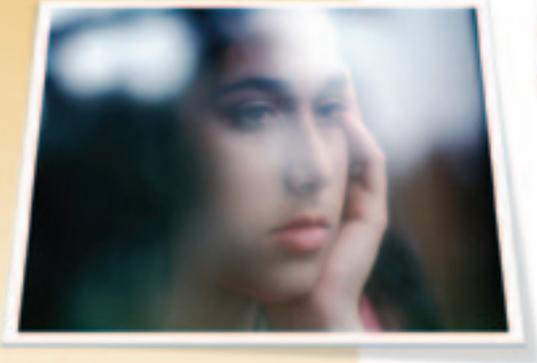
Answer: Using words like domestic violence or asking if someone is abused can be stigmatizing. Also, women in abusive or controlling relationships may not think these words apply to them because what is happening isn't bad enough. Many clients may imagine that women in violent relationships need to be acutely injured or hospitalized. Or they may say no to a screening question because they don't want the label of being abused—avoiding labels and describing behaviors.

Again this is someone looking to get a 'no' from the client, not a yes or positive disclosure of violence.

Question #5. Ask participants: What does this make you think of? Community violence, loose railings or floorboards, etc. This question isn't direct enough to establish safety in the relationship.

Scripts can include normalizing language:

- “So many of our moms are struggling in their relationships we have started asking everyone about their partners and how they are being treated....”
- Scripts should also address clients’ fears about what may or may not fall into your state’s mandatory reporting requirements.



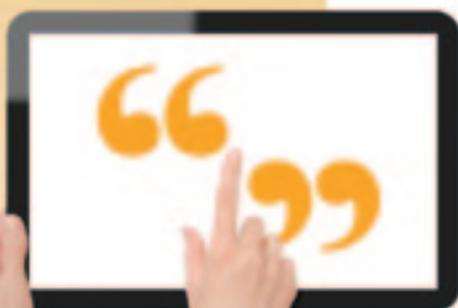
Notes to Trainer: It is important to keep in mind fears about immigration status and child welfare workers. This study overview may be interesting to read aloud to participants:

In a study by Renker & Tonkin (2006), 97% of women stated that they were not embarrassed, angry, or offended by their health care provider asking about domestic violence during prenatal care visits.

Renker P, Tonkin P. (2006) Women’s views of confidentiality issues related to and acceptability of prenatal violence screening. *Obstetrics and Gynecology*, V.107 N.2, February, 2006: 348-354

Example:
(check with
requirements
in your
county/state)

“Everything you share with me is confidential. This means what you share with me is not reportable to child welfare, INS (now Homeland Security) or law enforcement. There are just two things that I would have to report—if you are suicidal, or your children are being harmed.



The rest stays between us and helps me better understand how I can help you and the baby.”

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How does using the safety card support domestic violence screening?



Estimated Activity Time: 2–3 minutes

Notes to Trainer: Hand out the safety card *Healthy Moms, Happy Babies* to audience. This can be turned into a group discussion, quick debrief or small group activity.

Safety first! Never leave this card for the client without going over it with her—it may put her at risk if her partner accidentally finds it. After reviewing the card ask your client if it is safe to leave the card.

This card was developed with the clients safety in mind and modeled after the ‘shoe card’ that domestic violence advocates have used for years—making it easier for the client to hide.

To turn the card to a staff prompt you would just need to change the wording on the card to make it an assessment tool. Example from the card: “Do I feel respected, cared for and nurtured by my partner?” Can easily be changed to: “Do **you** feel respected, cared for and nurtured by **your** partner?” This works with the other sections of the card as well.

Home visitors can introduce this card and say: “We started giving this card to all our moms. It talks about healthy and safe relationships, it’s kind of like a magazine quiz...” How else might you start the conversation about the card?

Take a minute to think about how you might introduce the card. Debrief ideas with the group.

How is it Going?

All moms deserve healthy relationships. Ask yourself:

- ✓ Do I feel respected, cared for and nurtured by my partner?
- ✓ Does my partner give me space to be with friends or family (or to take breaks from the baby)?
- ✓ Does my partner support my decisions about if or when I want to have more children?

If you answered *YES* to any of these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, longer life, and better outcomes for children.



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Notes to Trainer: This is the second panel of the safety card *Healthy Moms, Happy Babies*.

On Bad Days?

Is my relationship unsafe or disrespectful? Ask yourself:

- ✓ Does my partner shame or humiliate me?
- ✓ Does my partner threaten me, hurt me, or make me feel afraid?
- ✓ Does my partner force me to do sexual things I don't want to?
- ✓ Does my partner threaten to hurt my children or my family?

If you answered *YES* to any of these questions, you don't deserve to be hurt and your home visitor can support you and connect you to helpful programs.



Note to Trainer: This section of the card reflects portions of the self-administered Relationship Assessment (see handout) and can be used as a way to introduce that tool. “This section is similar to this questionnaire we are doing with all our moms, so why don’t we take a minute and have you do that now?”

What to do with a negative screen for domestic violence: “I’m glad nothing like this is going on for you. Because many women are in unhealthy or abusive relationships, we are giving this card to all our moms so you will know how to help a friend or family member...”

What does your home visitor have to report to the authorities?

- Child abuse and neglect.
- A few states require that domestic violence must be reported to the police, others do not.
- A few states have laws that view domestic violence and/or substance abuse as child abuse and this can result in a report to child welfare.

You have the right to know what your home visitor is required to report. Ask your home visitor about what is reportable and to whom.



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Notes to Trainer: This section of the card highlights home visitation staff's responsibility to understand state reporting laws and lets clients know that they can turn to you for important information in this area. It may be useful to refer back to slide 28 and the study done by Renker to highlight the importance of knowing and informing clients about reporting laws. (For additional information on reporting issues please see Module 11 of this curriculum).

A good, evidence based tool to use with clients but consider:

Almost a quarter of all adult
Americans read at or below a
5th grade level.

(review verbally if needed)



Notes to Trainer: Once you have reviewed the card, next review the Relationship Questionnaire. The script at the top of the page is set up to be modified state by state—please encourage participants to make the changes to this assessment tool before using in the field. It may be necessary to read all the questions on the tool aloud to your client, taking a moment to make sure they understand what is being read to them. “So let’s go over this Relationship Assessment Tool together, here is how the scoring for each question works. So for question #1 looking at this scale (read entire scale to client) what number best reflects how you feel?”

“Everything you share with me today is confidential unless (*NOTE: Participants must double check state law and insert here—this may also include any reports to child welfare for witnessing domestic violence or mandatory reports to police for injury associated with domestic violence for adult women*) you were to tell me that you are going to hurt yourself, someone has hurt you with a weapon, or your children are being harmed. Those things I would have to report, ok?”

Next train home visitors on how to offer support, safety planning and referral if a client scores over 20 on the Relationship Questionnaire. Validate, do a safety plan and refer her to domestic violence advocacy services.

AMA: Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs. Health literacy: report of the Council on Scientific Affairs. JAMA. 1999;281: 552-557.

Can talking about abuse make a difference?

Your recognition and validation
of her situation is important.

You can help:

- Reduce her sense of isolation and shame
- Encourage her to believe a better future is possible



What Should You do When You Get a Positive Disclosure of Domestic Violence?



Validate:

- “I’m so sorry this is happening in your life, you don’t deserve this”
- “It’s not your fault”
- “I’m worried about the safety of you and your children”

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Where Should You Document Safety Plans and Referrals?

Document:

- On pages 2 and 3 of the Relationship Assessment Tool
- Safety planning is addressed both in the *Healthy Moms, Happy Babies* Safety Card and Appendix F of this curriculum



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Notes to Trainer: Documentation of what you discussed is important. Using the Relationship Assessment Tool, all you need to do is circle the options to record what you have offered or given your client.

Every client should be given the *Healthy Moms, Happy Babies* card unless it is unsafe for her to take it. Always double check to see if it is ok to leave the card with her.

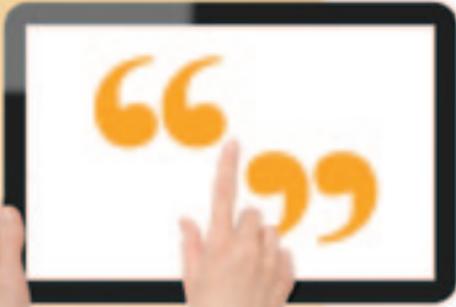
IMPORTANT! The *Healthy Moms, Happy Babies* card should be given (unless it is unsafe for her to take it) to all clients no matter whether their scores are high or low on the Relationship Assessment Tool.

Some women will not be comfortable recording how bad things are in their relationship and sharing that information with her home visitor, but can benefit from receiving the information on the card.



When Domestic Violence is Disclosed: Provide a 'Warm' Referral

- “I want to go over this section of the safety card I gave you before, if you ever need to get out of the house quickly it is so helpful to have planned out what you will do and this can help remind you about your next steps”
- Offer referral: “If you are comfortable with this idea I would like to call my colleague at the local program (fill in person's name) Jessica, she is really an expert in what to do next and she can talk with you about supports for you and your children from her program...”



Notes to Trainer: Getting to know your local DV program staff will help ensure that each referral feels genuine and supportive to your clients.

Safety Planning

If you are being hurt by a partner it is not your fault. You deserve to be safe and treated with respect.

If your safety is at risk:

- 1.** Call 911 if you are in immediate danger.
- 2.** Prepare an emergency kit in case you have to leave suddenly with: money, checkbook, keys, medicines, a change of clothes, and important documents.
- 3.** Talk to your home visitor for help calling the local or national domestic violence hotline for additional information on safety planning.



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Notes to Trainer: This is the section of the safety card you are referring to on the previous slide.

Role of the Domestic Violence Advocate



- Domestic violence advocates provide safety planning and support
- Safety planning is designed to assist mothers and children who have experienced domestic violence to think and act in a way to increase personal safety
- Home visitors can help clients connect with an advocate to work on a safety plan and additional services like:
 - Housing
 - Legal advocacy
 - Support groups/counseling



Notes to Trainer: Contact the nearest domestic violence shelter or the domestic violence coalition in your state to talk with domestic violence advocates and learn more about safety planning, training, and resources for families who have experienced violence in a relationship.

Amber Video Clip



The following video clip demonstrates how to screen for domestic violence and educate about safety planning and referrals even when the client isn't open to accepting referrals for domestic violence.



Estimated Activity Time: 10 minutes to watch video and 10 minutes for discussion

Discussion questions to ask after watching this video clip include:

1. Let's start by discussing the opening of the video—what do you think about the way the home visitor began the visit with mom?
2. How do you think the presentation of the *Healthy Moms, Happy Babies* card went? Did it feel judgmental or supportive to you? The goal with this question is to get the audience to think about the way the card was introduced and how the home visitor suggests the card can be used for a friend or a family member.
3. What do you think about the way that Lonna (Home Visitor) handled the way Amber responded to the Relationship Assessment Tool? What did you like about it and what would you change?
4. What did you think about the situation shown between the two home visitors at the end of the video? How many of you have an opportunity to debrief with colleagues about difficult situations with your clients?
5. Any final thoughts about what you saw? Doable? Concerns?

Taking Control Back

Referrals Can Help

Getting support for yourself and your children can help you move toward a healthier future—even the smallest step is something to celebrate.

While local and national domestic violence programs can help with safety planning and provide referrals to safe shelters, they also provide services for women who may not want or be ready to go to shelter. Many programs have:

- drop-in support groups for women and programs for children.
- classes to build confidence, plan for the future and support your parenting—call your local program to find out what is available.



Notes to Trainer: Many people think domestic violence programs provide only shelter beds. This panel of the card can help clients understand the range of services available in their community.

Providing a
'Warm'
Referral to
The National
Hotline

“On the back of this card there are national confidential hotline numbers and the people who work there really care and have helped thousands of women. They are there 24/7 and can help you find local referrals too—and often can connect you by phone...”



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Notes to Trainer: If there are not any local resources or you do not have information about local referrals, the National Domestic Violence Hotline can help.



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Funded by the Administration on Children,
Youth and Families, U.S. Department of
Health and Human Services and the Office
on Women's Health, U.S. Department of
Health and Human Services.

**National hotlines can connect
you to your local resources and
provide support:**

For free help 24 hours a day, call:

**National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224**

**Teen Dating Abuse Hotline
1-866-331-9474**

**Rape, Abuse, Incest,
National Networks (RAINN)
1-800-656-HOPE (1-800-656-4673)**



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Notes to Trainer: This is the panel of the safety card referred to in the previous slide.

Role Play (Option 1)

"Your client, Stephanie, is a 24-year-old mother of four children. Using *Healthy Moms, Happy Babies* safety card, please review the first two panels of the card and follow the key steps you just learned to best help the client with safety planning and referral.

(Clients, please answer yes to at least one question from the 'On Bad Days' section of the *Healthy Moms, Happy Babies* safety card).



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Estimated Activity Time: 15-20 minutes

Directions for Role Play

- Divide participants into groups of three.
- Advise participants that one person will role play the home visitor, one is the client and the third person is the observer.
- Advise the person who is role playing the home visitor to use the panel of the card to assess for a controlling relationship.
- Read the scenario, as shown on the slide, aloud to participants: "Your client, Stephanie, is a 24-year-old mother of four children. Using *Healthy Moms, Happy Babies* safety card, please review the first two panels of the card (clients, please answer yes to at least one question from the On Bad Days? section of the *Healthy Moms, Happy Babies* safety card) and follow the key steps you just learned to best help client with safety planning and referral.
- Allow 10 minutes for the role play.
- Ask participants who were the observers of the interaction to think about the kinds of things that the home visitor said that worked well, such as how did she/he introduce the card? Did she/he make the discussion comfortable? What would they have liked to see more of? Did the provider do safety planning with the client? How did the home visitor handle describing the hotline numbers on the back of the card?
- Ask the participants who role played the client how the assessment made them feel.
- Ask participants who role played the home visitor if they were comfortable asking these questions. If some of the home visitors indicated that they were not comfortable, ask what would help to increase their comfort level.
- Ask participants who were the observers to share their thoughts and observations about what they liked and thought would be helpful.
- If there is enough time, you can ask groups to switch roles and do the role play again.

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Futures Without Violence

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Notes to Trainer:

- You do not need to be an expert in domestic violence to help women in your home visitation program.
- Our job is not to “fix” domestic violence or to tell victims what to do.
- Providing support and information can make a difference in the lives of victims.
- We can help victims by understanding their situation and recognizing how abuse can impact health, risk behaviors and parenting.

To Order
More of
These
Free Cards:

www.futureswithoutviolence.org/health



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Danger Assessment Tool



- 20-question tool designed to assess for risk of severe injury and potentially lethal assault by a current or former partner
- Used by domestic violence advocates and other service providers
- On-line training and certification to use tool is available
- Can aid home visitors in recognizing indicators of high risk situations and facilitate safety planning

The absence of indicators on this tool does not mean that a woman is not at risk.



Notes to Trainer: Some programs may consider getting training and certification to use the danger assessment tool. Others programs may refer to DV programs who may use it with clients.

Additional
Resources:
Helping an
Abused
Woman
101 Things
to Know,
Say and Do

Includes information on the dynamics of abuse, 10 points about coping with abuse, 10 promises not to make women, and handouts for clients.

Cost is \$30 plus shipping; order online
www.lfcc.on.ca

(Baker & Cunningham, 2008)

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Baker L, Cunningham A. Helping an Abused Woman: 101 Things to Know, Say and Do. 2008. www.lfcc.on.ca



Module 4: Impact of Domestic Violence on Perinatal Health Outcomes



Impact of Domestic Violence on Perinatal Health Outcomes



Module 4

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Module 4

Estimated Module Time: 20 minutes

Training Outline

- Learning objectives
- Large group discussion
- Effects of domestic violence around the time of pregnancy

Overview

Improving perinatal and birth outcomes are core goals for many home visitation programs. This module makes the connection between pregnancy and domestic violence including associated risk behaviors around the time of pregnancy that are associated with poor birth outcomes, low birth weight, interference with breastfeeding, and post-partum depression. By beginning with a large group discussion to identify these connections, participants demonstrate what they already know about domestic violence and pregnancy through their work and life experiences.

Learning Objectives

- 1** List three effects of domestic violence on women's risk behaviors during pregnancy.
- 2** List two effects of domestic violence on birth outcomes.
- 3** Describe the connection between domestic violence and breastfeeding.
- 4** Explain why women experiencing domestic violence are more likely to experience postpartum depression.



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Notes to Trainer: Read the learning objectives aloud.



How does domestic violence impact women's perinatal health and their birth outcomes?



Estimated Activity Time: 15 minutes

Notes to Trainer: For this activity, you will need a flipchart and markers.

- Ask participants to call out responses to the question “How does domestic violence impact women’s perinatal health and their birth outcomes?”
- Repeat participants’ responses, clarify as needed and give hints about what is missing. For example, if depression has not been mentioned the facilitator could ask , “So let’s talk about how this might impact moms’ feelings or emotional health...”
- If you are working with another trainer, one of you should be the note-taker. The note-taker records what the participants call out onto the flipchart and then tapes sheets when they are full around the room so the responses can be seen by the audience.
- When the trainer feels that some of the key effects have been identified, move forward through the next slides in this module to review and highlight examples that were given, as well as anything that was missing.

Homicide is the second leading cause of injury-related deaths among pregnant women.



(Chang et al, 2005)



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Notes to Trainer: Inform participants that a majority of female homicides are women who were murdered by a current or former intimate partner.

Pregnancy-associated homicides were analyzed with a national dataset (1991-1999) from the Pregnancy Mortality Surveillance System at the Centers for Disease Control and Prevention for this study.

Pregnancy-associated injury deaths and homicides were defined as women who died during or within one year of pregnancy.

Of all pregnancy-associated injury deaths, motor vehicle accidents was the leading cause (44.1%) and homicide was the second leading cause (31.0%). The rest of the pregnancy-associated injury deaths were attributed to unintentional injuries (12.7%), suicides (10.3%), and other (2.0%).

Chang J, Berg CJ, Saltzman LE, Herndon J. Homicide: A Leading Cause of Injury Deaths Among Pregnancy and Postpartum Women in the United States, 1991-1999. *American Journal of Public Health*. 2005;95(3):471-477.



Women Who Experience Abuse Around the Time of Pregnancy Are More Likely to:

- Smoke tobacco
- Drink during pregnancy
- Use drugs
- Experience depression, higher stress, and lower self-esteem
- Attempt suicide
- Receive less emotional support from partners

(Amaro, 1990; Bailey & Daugherty, 2007; Berenson et al, 1994; Campbell et al, 1992; Curry, 1998; Martin et al, 2006; Martin et al, 2003; Martin et al, 1998; McFarlane et al, 1996; Perham-Hester & Gessner, 1997)



Experiencing domestic violence around the time of pregnancy has been shown to be associated with substance abuse, mental health problems, and other risk behaviors that are associated with poor pregnancy outcomes.

Amaro H, Fried LE, Cabral H, Zuckerman B. Violence During Pregnancy and Substance Use. *American Journal of Public Health*. 1990;80(5):575-579.

Bailey BA, Daugherty RA. Intimate Partner Violence During Pregnancy: Incidence and Associated Health Problems in a Rural Population. *Maternal and Child Health Journal*. 2007;11(5):495-503.

Berenson AB, Wiemann CM, Wilkinson GS, Jones WA, Anderson GD. Perinatal Morbidity Associated with Violence Experienced by Pregnant Women. *American Journal of Obstetrics and Gynecology*. 1994;170:1760-1769.

Campbell JC, Poland ML, Waller JB, Ager J. Correlates of Battering During Pregnancy. *Research in Nursing and Health*. 1992;15:219-226.

Curry MA. The Interrelationships Between Abuse, Substance Use, and Psychosocial Stress During Pregnancy. *JOGNN*. 1998;27(6):692-699.

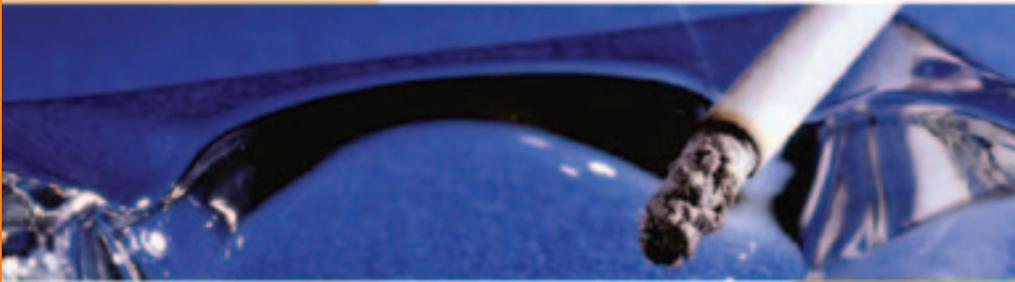
Martin SL, Beaumont JL, Kupper LL. Substance Use Before and During Pregnancy: Links to Intimate Partner Violence. *American Journal of Drug and Alcohol Abuse*. 2003;29:599-617.

Martin SL, Kilgallen B, Dee DL, Dawson S, Campbell JC. Women in Prenatal Care/Substance Abuse Treatment Programme: Links between Domestic Violence and Mental Health. *Journal of Maternal and Child Health*. 1998;2:85-94.

McFarlane J, Parker B, Soeken K. Physical Abuse, Smoking and Substance Abuse During Pregnancy: Prevalence, Interrelationships and Effects on Birth Weight. *Journal of Obstetrics, Gynecology and Neonatal Nursing*. 1996;25:313-20.

Perham-Hester KA, Gessner BD. Correlates of Drinking During the Third Trimester of Pregnancy in Alaska. *Maternal and Child Health Journal*. 1997;1(3): 165-172.

42% of women experiencing some form of DV could not stop smoking during pregnancy compared to **15%** of nonabused women.



(Bullock et al, 2001)

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In this retrospective study by Bullock et al. (2001), rural postpartum women (n=293) were interviewed during their hospital stay about their tobacco use and experiences with DV. DV was measured with the Abuse Assessment Screen which includes questions on physical, sexual, and emotional abuse within the past year and since pregnancy. The rate of smoking among abused women during pregnancy is in agreement with other **prospective studies** that found between **44% and 60%** of abused women continue to smoke during pregnancy.

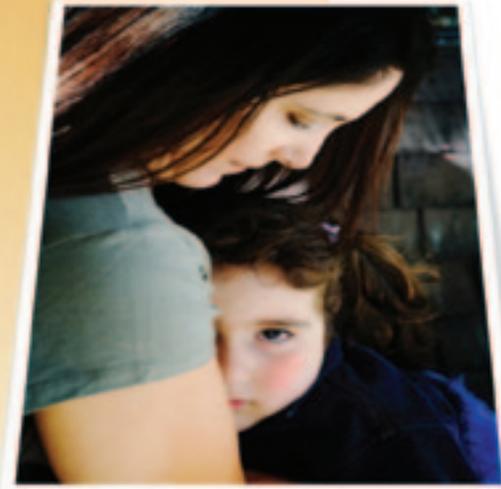
Bullock LFC, Mears JLC, Woodcock C, Record R. Retrospective Study of the Association of Stress and Smoking During Pregnancy in Rural Women. Addictive Behaviors. 2001;26:405-413.



Psychological abuse by an intimate partner was a stronger predictor than physical abuse for the following health outcomes for female and male victims:

- Depressive symptoms
- Substance use
- Developing a chronic mental illness

(Coker et al, 2002)

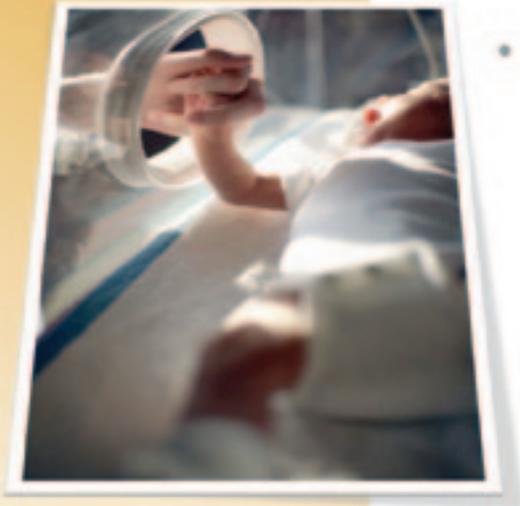


In this study:

- Women were significantly more likely than men to experience physical or sexual abuse and abuse of power and control by an intimate partner compared to men.
- Both physical and psychological abuse by an intimate partner were associated with significant physical and mental health problems for male and female victims.

Coker AL, Smith PH, Thompson MP, McKeown RE, Bethea L, Davis KE. Social Support Protects Against the Negative Effects of Partner Violence on Mental Health. *Journal of Women's Health & Gender-Based Medicine*. 2002;11(5):465-476.

Domestic Violence During Pregnancy is Associated With



- **Lower gestational weight gain during pregnancy** (Moraes et al, 2006)
- **Low and very low birth weight** (Lipsky et al, 2003)
- **Pre-term births** (Silverman et al, 2006)

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Numerous studies have documented the impact of domestic violence on pregnancy. An overview of the effects of domestic violence on women's reproductive health and pregnancy can be found in a review study by Sarkar (2008).

Lipsky S, Holt VL, Esterling TR, Critchlow C. Police-Reported Intimate Partner Violence During Pregnancy and Risk of Antenatal Hospitalization. *Maternal and Child Health Journal*. 2009;8(2):55-63.

Moraes CL, Amorim AR, Reichenheim ME. Gestational Weight Gain Differentials in the Presence of Intimate Partner Violence. *International Journal of Gynaecology and Obstetrics*. 2006;95:254-260.

Silverman JG, Decker MR, Reed E, Raj A. Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health. *American Journal of Obstetrics and Gynecology*. 2006;195:140-148.

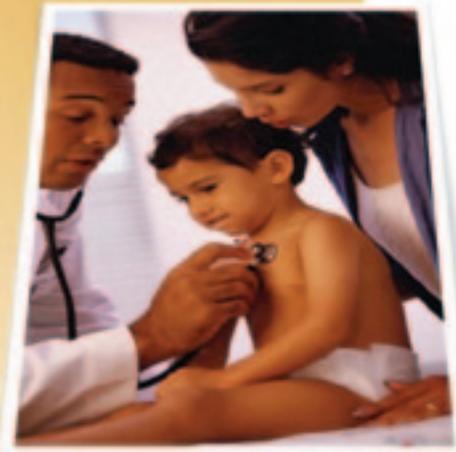
Sarkar NN. The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. *Journal of Obstetrics and Gynaecology*. 2008;28(3):266-271.



Women experiencing physical abuse around the time of pregnancy are:

35%-52% less likely to breastfeed their infants

41%-71% more likely to cease breastfeeding by 4 weeks postpartum



(Silverman et al, 2006)



This study analyzed data from 26 U.S. states that participated in the 2000-2003 Pregnancy Risk Assessment Monitoring System (PRAMS).

Domestic violence (DV) was measured by two questions as follows:

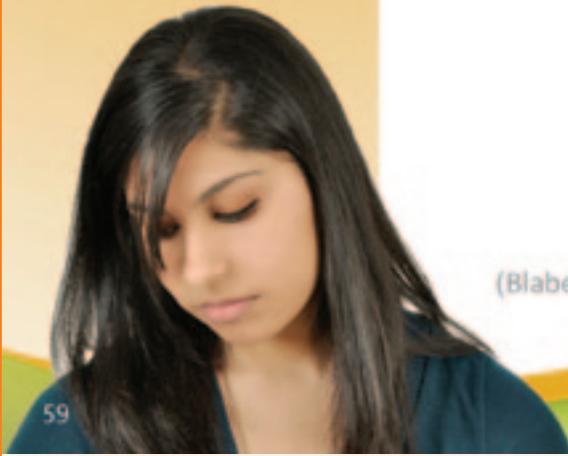
- “During the 12 months before you got pregnant, did your husband or partner push, hit, slap, kick, choke or physically hurt you in any other way?”
- “During your most recent pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?”

Women who reported DV in the year prior to pregnancy but not during pregnancy, women who reported DV during pregnancy but not in the year prior to pregnancy, and women who reported DV during the year prior to pregnancy and during pregnancy were significantly less likely to breastfeed their infants.

Silverman JG, Decker MR, Reed E, Raj A. Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health. *American Journal of Obstetrics and Gynecology*. 2006;195:140-148.

Women with a controlling or threatening partner are **5X** more likely to experience persistent symptoms of postpartum maternal depression

(Blabey et al, 2009)



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This data is from the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). Women completed a survey within a few months after delivery and were then contacted again approximately two years later.

Blabey MH, Locke ER, Goldsmith YW, Perham-Hester KA. Experience of a Controlling or Threatening Partner Among Mothers with Persistent Symptoms of Depression American Journal of Obstetrics & Gynecology. 2009;201:173.e1-9.



Use This Card
to Help
Make
Connections
Between
Depression,
Substance
Abuse,
and DV



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Coping Strategies

How is your health, how are you coping? Ask yourself:

- ✓ Do I feel so sad I can't get out of bed? Or take care of the baby?
- ✓ Am I smoking more to try and calm myself?
- ✓ Am I using alcohol, prescription medications, or other drugs to make the pain go away?
- ✓ Do I ever feel so sad that I have thoughts of suicide?

If you answered *YES* to any of these questions, it may be the result of chronic stress. Talk with your home visitor right away about how to get help.



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Notes to Trainer: Home visitors can reintroduce the card with a focus on this panel like this: “You might remember this card I showed you before? I want to talk about this panel today because we are going to be talking about depression and it helps connect some of the ways people cope when they are in stressful relationships...”

It is important to note that this card can be used in conjunction with substance abuse, depression and tobacco cessation assessment tools.



**Module 5: Making the
Connection: Domestic
and Sexual Violence,
Birth Control
Sabotage, Pregnancy
Pressure, and
Unintended
Pregnancies**



Making the
Connection:
**Domestic and
Sexual Violence,
Birth Control
Sabotage,
Pregnancy
Pressure, and
Unintended
Pregnancies**



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Module 5

Estimated Module Time: 65 minutes

Training Outline

- Learning objectives
- Definitions, statistics, and examples of reproductive coercion
- Group discussion: birth control sabotage
- Assessment for reproductive coercion and responding to disclosures
- Role play (slide)

Overview

As we have learned more about different forms of abusive and controlling behaviors that are used by partners to maintain power and control in a relationship, patterns of behaviors that affect women's reproductive health have been identified. These behaviors, which are referred to as reproductive coercion, include forced sex, birth control sabotage, pregnancy pressure, and condom manipulation. Using a skills-based approach, this module includes assessment questions, scripting, and information about birth control options that may be less visible and more effective for clients whose partners are interfering with their birth control.

Learning Objectives

- 1 Define reproductive coercion.
- 2 List three examples of birth control sabotage.
- 3 Demonstrate two assessment questions for reproductive coercion.
- 4 Identify two birth control methods that you can discuss with a client who discloses that she is worried about getting pregnant due to her partner's interference with her birth control methods.

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Notes to Trainer: Read the learning objectives aloud.

Definition:
Reproductive
Coercion

Reproductive Coercion

involves behaviors that a partner uses to maintain power and control in a relationship that are related to reproductive health:

- Explicit attempts to impregnate a partner against her wishes
- Controlling outcomes of a pregnancy
- Coercing a partner to have unprotected sex
- Interfering with birth control methods



Domestic violence
increases women's
risk for

Unintended Pregnancies



(Sarkar, 2008)



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Sarkar conducted a literature review of publications from 2002 through 2008 on the impact of domestic violence on women's reproductive health and pregnancy outcomes.

In a study by Goodwin et al (2000), women who had unintended pregnancies were 2.5 times more likely to experience physical abuse compared to women whose pregnancies were intended.

Goodwin MM, Gazmararian JA, Johnson CH, et al. Pregnancy Intendedness and physical abuse around the time of pregnancy: Findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. Maternal and Child Health Journal. 2000;4(2):85-92.

Sarkar NN. The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. Journal of Obstetrics and Gynaecology. 2008;28(3):266-271.



Why is Reproductive Coercion Important?

Rapid Repeat Pregnancy

Adolescent mothers who experienced physical abuse within three months after delivery were **nearly twice** as likely to have a repeat pregnancy within 24 months



(Raneri & Wiemann, 2007)



In this study with teenage mothers (ages 12-18) who were recruited from a labor and delivery unit at a university hospital, physical abuse by an intimate partner was defined as being hit, slapped, kicked, or physically hurt enough to cause bleeding or having been hit during an argument or while her partner was drunk or high.

The odds of repeat pregnancy was 1.9 times higher among teen mothers who were physically abused by their partner within three months of delivery compared to non-abused teen mothers.

Raneri LG, Wiemann CM. Social Ecological Predictors of Repeat Adolescent Pregnancy. *Perspectives on Sexual and Reproductive Health*. 2007;39(1):39-47.

“I’m not gonna say he raped me, he didn’t use force, but I would be like, “No” and then next thing, he pushes me to the bedroom, and I’m like “I don’t want to do anything” and then we ended up doing it, and I was crying like a baby and he still did it. And then after that he got up, took his shower, and I just stayed there like shock.”

17 yr. old female

(Miller et al, 2007)



This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. The teen girl was parenting a baby from a different relationship and the abusive relationship started shortly after she broke up with her son’s father. She went to a teen clinic and started Depo-Provera injections without her new partner’s knowledge.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*. 2007;7(5):360-366.



Women and girls who are victims of DV are **4x** more likely to be infected with HIV



(Decker, 2005)



Decker MR, Silverman JG, Raj A. Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis among Adolescent Females. *Pediatrics*. 2005;116(2):e272-276.

“ Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid.” ”

17 yr. old female who started Depo-Provera without partner's knowledge

(Miller et al, 2007)

This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. The teen girl was parenting a baby from a different relationship and the abusive relationship started shortly after she broke up with her son's father. She went to a teen clinic and started Depo-Provera injections without her new partner's knowledge.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*. 2007;7(5):360-366.





What are other ways a partner can interfere with a woman's birth control?

Estimated Activity Time: 3-5 minutes

1. Ask participants to give some examples of birth control sabotage.
2. Proceed to the next slide which provides examples of birth control sabotage and highlight any examples that were not identified by participants.

Tactics include:

- Destroying or disposing contraceptives
- Impeding condom use (threatening to leave her, poking holes in condoms)
- Not allowing her to obtain or preventing her from using birth control
- Threatening physical harm if she uses contraceptives



Qualitative and quantitative research have shown an association between birth control sabotage and domestic violence.

Fanslow et al. (2008) conducted interviews with a random sample of 2,790 women who had ever had sexual intercourse. Women who had ever experienced domestic violence were more likely to have had partners who refused to use condoms or prevented women from using contraception compared to women who had not experienced domestic violence (5.4% vs. 1.3%).

Miller et al (2007) conducted interviews with 53 sexually active adolescent females. One-quarter (26%) of participants reported that their abusive male partners were actively trying to get them pregnant. Common tactics used by abusive male partners included:

- Manipulating condom use
- Sabotaging birth control use
- Making explicit statements about wanting her to become pregnant

Campbell J, Pugh LD, Campbell D, Visscher M. The Influence of Abuse on Pregnancy Intention. *Women's Health Issues*. 1995;5:214-223.

Coggins M, Bullock LF. The Wavering Line in the Sand: the Effects of Domestic Violence and Sexual Coercion. *Issues in Mental Health Nursing*. 2003;24(6-7):723-738.

Fanslow J, Whitehead A, Silva M, Robinson E. Contraceptive Use and Associations with Intimate Partner Among a Population-based Sample of New Zealand Women. *Australian & New Zealand Journal of Obstetrics & Gynaecology*. 2008;48(1):83-89.

Lang DL, Salazar LF, Wingood GM, DiClemente RJ, Mikhail I. Associations Between Recent Gender-based Violence and Pregnancy, Sexually Transmitted Infections, Condom Use Practices, and Negotiation of Sexual Practices Among HIV-Positive Women. *Journal of Acquired Immune Deficiency Syndromes*. 2007;46(2):216-221.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*. 2007;7(5):360-366.

Wingood GM, DiClemente R. The effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African-American Women. *Journal of Public Health*. 1997;87:1016-1018.

Among teen mothers on public assistance who experienced recent domestic violence:

- **66%** experienced birth control sabotage by a dating partner
- **34%** reported work or school-related sabotage by a dating partner



(Raphael, 2005)



In this study by Raphael (2005), 474 teen girls on Temporary Assistance to Needy Families completed written surveys. The teens were recruited from two state-funded Teen Parent Services sites and two community-based health clinics. Seventy percent were between the ages of 15 and 17 at the time of the birth of their first infant (mean =18 years) and 95% of the girls were African Americans. Almost half (43%) of the girls were involved with males who were older by 4 or more years. Fifty-five percent disclosed domestic violence in the past 12 months. Findings included:

- Two-thirds (66%) of teen dating violence victims experienced birth control sabotage compared to 34% of non-abused teens
- 34% of teen dating violence victims reported work or school related sabotage compared to 7% of teens who did not experience dating violence but were sabotaged in relation to work or school.

Raphael J. Teens Having Babies: The Unexplored Role of Domestic Violence. *The Prevention Researcher*. 2005;12(1):15-17.

Use the *Loving Parents, Loving Kids* Safety Card

Let's Talk Pregnancy

- Does my partner support my decisions about if or when I want to have more children?
- Does my partner refuse to use condoms when I ask?
- Does my partner make me have sex when I don't want to?
- Has my partner ever tried to get me pregnant (recently or in the past) when I didn't want to be?

Unplanned pregnancies, especially if they are closely timed after your first pregnancy--can make it difficult to care for the children you already have.



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Notes to Trainer: Please hand out the *Loving Parent, Loving Kids* safety cards to participants.

Advise participants that they can order the cards from Futures Without Violence www.FuturesWithoutViolence.org (write the website on the flipchart). If you do not have the cards available, then use this to discuss the safety card and give everyone ample time to review it so that they can use that information in the role play.

Review these sample assessment questions from the *Loving Parents, Loving Kids* safety card and ask participants how well these questions would work with their clients and their comfort level asking these questions.



“I'm really glad you told me about what is going on—it happens to a lot of women and it is so stressful to worry about getting pregnant when you don't want to be. I want to talk with you about some methods of birth control that your partner doesn't have to know about like Implanon or the IUD—so you don't have to worry about unplanned pregnancy.”



Notes to Trainer: Implanon is a 3-year implantable contraceptive (etonogestrel). It is a progestin-only method and does not contain estrogen. Information about Implanon and the IUD can be found on the handout “Birth Control Education Handout” (see next slide).

Birth Control Methods That Are Less Likely to be Detected by a Sexual Partner



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Notes to Trainer: Provide the handout Birth Control Education Handout and discuss two or three examples that are listed on the handout including the information provided about that example. Ask participants if they are familiar with the methods described in the handout. If participants indicate that they are not familiar with these methods, brainstorm about how they can learn more about them. For example, asking someone from a local reproductive health clinic to come to talk to their program about these methods and what is available locally.

Use the *Loving Parents, Loving Kids* Safety Card

Taking Control

Your partner may see pregnancy as a way to keep you in his life and keep connected to you through a child—even if that isn't what you want.

If your partner pushes you to have sex, messes with your birth control or refuses to use condoms:

1. Talk with your health care provider about birth control that you can control and that your partner doesn't have to know about (examples--IUD, Emergency Contraception (EC), Depo, Implanon).
2. Ask your home visitor about local and national programs to help women struggling in their relationships with control or abuse.



Notes to Trainer: Review these intervention strategies from the *Loving Parents, Loving Kids* safety card. Highlight the importance of having local reproductive health referrals to support mothers experiencing reproductive coercion.

Follow-up to Disclosure of Birth Control Sabotage



“What you’ve told me also makes me worried about your health and safety in other ways. Sometimes when a partner is trying to get you pregnant when you don’t want to be they might also try and control or hurt you in other ways.”

“Is anything like this happening in your relationship?”

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Notes to Trainer: This is a good example of where to reintroduce the Relationship Assessment Tool and have the client review it with you for any changes.





- 1** Validate client's experience.
- 2** Offer a safety card for client to review and keep if it is safe to do so.
- 3** Discuss where client can go to learn more about and obtain birth control options.
- 4** Ask client if she has immediate safety concerns and discuss options.
- 5** Refer to a domestic violence advocate for safety planning and additional support.
- 6** Follow up at next visit.

- "I'm glad you talked to me about this today."
- "I'm so sorry this happening in your life, you don't deserve this."
- "It's not your fault."
- "I'm worried about the safety of you and your children."
- "You deserve to be treated with respect."

Marta Video Clip



The following video clip demonstrates an approach to integrated assessment for postpartum depression, reproductive coercion and domestic violence in a home visitation setting.



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Estimated Activity Time: 10 minutes to watch video “Marta: Home Visitation Visit – Assessment for Post Partum Depression and Domestic Violence” and 10 minutes for discussion.

Discussion questions to ask after watching this video clip include:

1. What do you think worked well?
2. What did not work well?
3. Were there some other questions that should have been asked? (Assessment for hurting the kids should have been included in the depression assessment for example.)
4. How could this approach to integrated assessment be adapted for home visits?
5. How many of you have ever called the hotline “just to see what it was like?” Was this approach effective?
6. What kinds of examples did you see to help “normalize” the conversation?



Your client is a 19-year-old mother of a newborn infant. Review the “Let’s Talk Pregnancy” and then use the *Loving Parents, Loving Kids* safety card to discuss unwanted sex, birth control sabotage, and ability to negotiate pregnancy spacing with your client.



Exercise Activity Time: 15 minutes

Directions for role play:

- Divide participants into groups of three.
- Advise participants that one person will role play the home visitor, one is the client, and the third person is the observer.
- Advise the person who is role playing the home visitor to use the “Let’s Talk Pregnancy” panel of the card to assess for reproductive coercion.
- Read the scenario, as shown on the slide, aloud to participants:

“Your client is a 19 year old mother of a newborn infant and the discussion is about pregnancy spacing. Using the *Loving Parents, Loving Kids* safety card, review the panel, “Let’s Talk Pregnancy,” and ask your client questions about her ability to negotiate unwanted sex, any experiences with birth control sabotage, and her ability to negotiate pregnancy spacing.”
- Allow 3-5 minutes for the role play.
- Ask the observers to think about the kinds of things that the home visitor said that worked well such as how did she/he introduce the card? Did she/he make the discussion comfortable? What would they have liked to see more of?
- Ask the participants who role played the client how the assessment made them feel.
- Ask participants who role played home visitors if they were comfortable asking these questions. If some of the home visitors indicated that they were not comfortable, ask what would help to increase their comfort level.
- Ask the observers to share their thoughts and observations about what they liked and thought would be helpful.
- If there is enough time you can ask groups to switch roles and do the role play again.

Reproductive Health and Partner Violence Guidelines:



An Integrated Response to Intimate Partner Violence and Reproductive Coercion

This tool is available online:

www.FuturesWithoutViolence.org/health



Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion focuses on the transformative role of the reproductive health care provider in identifying and addressing intimate partner violence (IPV) and reproductive coercion.

Available in hard copy or as a PDF from the Futures Without Violence online store. To place orders, visit www.FuturesWithoutViolence.org/health

Resource: Website on Assessment

- Women's stories about their experience with reproductive coercion



- Clinical and patient tools



www.knowmoresaymore.org



Resource: www.knowmoresaymore.org

Module 6: The Effects of Domestic Violence on Children

A photograph of two young children, a girl with blonde hair in a ponytail and a boy, sitting on the floor and drawing together. The girl is holding a red marker and coloring a drawing. The boy is looking on. The background is slightly blurred, showing other people in the room.

The Effects of Domestic Violence on Children



Module 6

Estimated Module Time: 45 minutes

Training Outline

- Learning objectives
- Large group discussion on the effects of domestic violence on children
- *First Impressions* DVD
- Large group discussion on strategies to help children exposed to domestic violence
- Resources

Overview

One of the important advances in the field of domestic violence has been research on how exposure to violence affects children. Early trauma such as chronic exposure to domestic violence can lead to predictable physical, mental, behavioral, and cognitive problems for children.

There are also implications for early brain development, as described in the DVD, *First Impressions*. Major advances in our understanding of early brain development explain why infants and younger children are especially vulnerable to trauma. The good news is that strengthening children's relationships with the non-battering parent and other supportive caregivers such as home visitors are protective factors that can help children cope with the stress of living in a home with domestic violence and heal from trauma.

Begin with a review of the learning objectives for this module. This is followed with a large group discussion on the effects of domestic violence on children. The goal for this large group discussion is for the audience's expertise to be highlighted and for them to use their knowledge to educate others around them. The following slides are for review purposes to note any effects that were not raised during the discussion. Most likely, home visitors will identify a wide range of effects on children that go well beyond the content of the slides.

Learning Objectives

- 1 List four examples of how exposure to domestic violence can impact children's physical and/or mental health.
- 2 From the DVD, **First Impressions**, describe one strategy that a mother described as helping her child to heal from exposure to domestic violence.



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Notes to Trainer: Read the learning objectives aloud.



"How does exposure to domestic violence affect children?"



Estimated Activity Time: 10-15 minutes

Notes to Trainer: The goal for this large group discussion is for the audience's expertise to be highlighted—to use their knowledge to educate those around them. Ideally, two people should work together to facilitate this section—one person guiding the discussion and one person recording participants responses on butcher paper, a blackboard, or some other means of recording and sharing feedback.

The facilitator asks the audience: "How does exposure to domestic violence affect children?" The facilitator should be prepared to repeat what is said and clarify and give hints about what is missing. For example, if anxiety and depression have not been mentioned the facilitator could ask, "So let's talk about how domestic violence might make children feel..."

The note-taker records what the participants call out. It is helpful for the note-taker also to repeat what is being said and clarify as needed as the responses are recorded.

When the facilitator feels that some of the key effects have been identified, the next three slides on the effects of violence on children can be reviewed to highlight examples that were given as well as anything that was missing.

Childhood
Exposure to
Domestic
Violence
Increases the
Likelihood of
Children
Experiencing

- Failure to thrive
- Bed wetting
- Speech disorders
- Vomiting and diarrhea
- Asthma
- Allergies
- Gastrointestinal problems
- Headaches

(Campbell and Lewandowski, 1997;
Graham-Bermann & Seng, 2005)



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Notes to Trainer: Many studies have shown that children who are exposed to violence have more physical health problems and these problems may persist after the violence has ended.

Campbell JC, Lewandowski LA. Mental and Physical Health Effects of Intimate Partner Violence on Women and Children. *Psychiatric Clinics of North America*. 1997;20(2):353-374.

Graham-Bermann SA, Seng J. Violence Exposure and Traumatic Stress Symptoms as Additional Predictors of Health Problems in High-risk Children. *Journal of Pediatrics*. 2005;146(3):349-354.

Children Exposed to Domestic Violence are at Significantly Higher Risk for

- Posttraumatic Stress Disorder
- Depression
- Anxiety
- Developmental delays
- Aggressiveness



(Edleson J, 1999; Graham-Bermann & Levendosky, 1998; Hurt et al, 2001; Lehmann, 2000; McCloskey & Walker, 2000; Pfouts et al, 1982; Spaccarelli et al, 1994; Wilden et al, 1991; Wolfe et al, 2003)



Children exposed to domestic violence are at much higher risk for mental health problems and have significantly higher usage of mental health services compared to children who are not exposed to domestic violence.

Edleson J. Children's Witnessing of Adult Domestic Violence. *Journal of Interpersonal Violence*. 1999;14:839-870.

Graham-Bermann SA, Levendosky AA. Traumatic Stress Symptoms in Children of Battered Women. *Journal of Interpersonal Violence*. 1998;13(1):111-128.

Hurt H, Malmud E, Brodsky NL, Giannetta J. Exposure to Violence: Psychological and Academic Correlates in Child Witnesses. *Archives of Pediatric Adolescent Medicine*. 2001;155:1351-1356.

Lehmann P. Posttraumatic Stress Disorder (PTSD) and Child Witnesses to Mother-Assault: A Summary and Review. *Children and Youth Services Review*. 2000;22(3/4):275-306.

McCloskey LA, Walker M. Posttraumatic Stress in Children Exposed to Family Violence and Single-Event Trauma. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2000;39:108-115.

Pfouts J, Schopler J, Henley H. Forgotten Victims of Family Violence. *Social Work*. 1982; July:367-368.

Spaccarelli S, Sandler IN, Roosa M. History of Spouse Violence Against Mother: Correlated Risks and Unique Effects in Child Mental Health. *Journal of Family Violence*. 1994;9(1):79-98.

Wilden SR, Williamson WD, Wilson GS. Children of Battered Women: Developmental and Learning Profiles. *Clinical Pediatrics*. 1991;30:299-304.

Wolfe DA, Crooks CV, Lee V, McIntyre-Smith A, Jaffe PG. The Effects of Children's Exposure to Domestic Violence: A Meta-Analysis and Critique. *Clinical Child and Family Psychology Review*. 2003; 6(3):171-187.

Childhood exposure to DV increases the likelihood of:



- More school nurse visits
- Referral to a school speech pathologist
- Frequent school absences
- Lower grade point averages
- School suspension

(Hurt et al, 2001, Kernic et al, 2002)

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Exposure to domestic violence has significant consequences for children's school performance.

Hurt H, Malmud E, Brodsky NL, Giannetta J. Exposure to Violence: Psychological and Academic Correlates in Child Witnesses. *Archives of Pediatric Adolescent Medicine*. 2001;155:1351-1356.

Kernic MA, Holt VL, Wolf ME, McKnight B, Hueber CE, Rivara FP. Academic and School Health Issues Among Children Exposed to Maternal Intimate Partner Abuse. *Archives of Pediatric and Adolescent Medicine*. 2002;156:549-555.

- 15-minute DVD
- For parents and caregivers
- Describes impact of DV on children
- Available at no cost from Futures Without Violence

(In English and Spanish)

www.futureswithoutviolence.org



Estimated Activity Time: 20 minutes

First Impressions is a DVD that is designed to educate adult caregivers and parents about the effects of exposure to violence on children's early brain development and their health. The DVD is available on the curriculum CD/DVD and is frequently used in trainings for service providers.

ACTIVITIES: *First Impressions* DVD and Large Group Discussion

- For this activity, you will need the *First Impressions* DVD, a DVD player and speakers. *First Impressions* is found on the CD/DVD provided for this training.
- Play the DVD ahead of the training to check the volume level for the speakers.
- *First Impressions* is approximately 15 minutes in length and is the first selection on the menu (the DVD also includes short clips from the DVD). You also have the option of playing the DVD in English or Spanish.
- After you have played *First Impressions*, ask participants to describe some strategies they could offer to a mother to help her children when they have been exposed to violence.
- Allow approximately 5 minutes for this group discussion; there is no note-taking for this discussion.



What are some strategies you can offer to a mother to help her children when they have been exposed to domestic violence?

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Notes to Trainer: Some of the strategies that we heard in the *First Impressions* DVD from parents who have experienced domestic violence and adult survivors who were exposed to domestic violence as children are listed below:

- Ask children how they are feeling and validate their feelings
- Increase quality time of parents/caregivers with the child
- Reach out to other caregivers to help them understand the child's situation and how they can be supportive
- Create lots of opportunities for exploring and learning to promote healthy brain development



**Module 7: Impact of
Domestic Violence on
Mothering: Helping
Moms Promote
Resiliency for Children**



Impact of Domestic Violence on Mothering: Helping Moms Promote Resiliency for Children



Module 7

Estimated Module Time: 30 minutes

Training Outline

- Learning objectives
- Information on the effects of violence on parenting
- Past exposure to violence and resiliency
- Strategies to strengthen mother-child bond

Overview

The impact of exposure to domestic violence goes beyond the health effects on women and children—it also can diminish parenting skills. There are important findings on how to build resiliency in the face of domestic violence and improve mother/child bonding. This module covers multiple tools that home visitors can use to help mothers and children thrive.

Learning Objectives

- 1** List two ways that domestic violence may affect a mother's parenting.
- 2** Describe the most consistent protective factor for children exposed to domestic violence.
- 3** Describe three core strategies to strengthen mother/child bonding.
- 4** Demonstrate the importance of developing a memorandum of understanding with local domestic violence programs.

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Notes to Trainer: Read the learning objectives aloud.

Mothers who experience domestic violence around the time of pregnancy have **lower maternal attachment** with their infants



(Quinlivan & Evans, 2005)



Despite excellence in prenatal care, domestic violence was associated with poorer maternal attachment and assessment of infant temperament in this study.

Poor maternal-infant attachment is associated with several negative outcomes for children including behavioral problems, aggression, and poorer social interaction.

Quinlivan JA, Evans SF. Impact of Domestic Violence and Drug Abuse in Pregnancy on Maternal Attachment and Infant Temperament in Teenage Mothers in the Setting of Best Clinical Practice. Archives of Women's Mental Health. 2005;8:191-199.

- Mothers who experienced DV were more likely to have maternal depressive symptoms and report harsher parenting
- Mothers' depression and harsh parenting were directly associated with children's behavioral problems



(Dubowitz et al, 2001)

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This study demonstrates the importance of educating victims about how DV can affect their mental health, their parenting skills, and ultimately, their children's well-being.

Dubowitz H, Black MM, Kerr MA, Hussey JM, Morrel TM, Everson MD, Starr RH. Type and Timing of Mothers' Victimization: Effects on Mothers and Children. *Pediatrics*. 2001;107(4):728-735.



Families with
domestic violence are

2X as Likely

to have a substantiated case of
child abuse compared to families
without domestic violence

(Rumm et al, 2000)



Domestic violence is a well-documented risk factor for child abuse.

Rumm PD, Cummings P, Krauss MR, Bell MA, Rivara FP. Identified spouse abuse as a risk factor for child abuse. Child Abuse and Neglect. 2000;24(11):1375-1381.

Domestic Violence is Predictive of Child Abuse

- Domestic violence during the first 6 months of a child's life was predictive of child abuse up to the child's fifth birthday among home-visited families
- Domestic violence preceded child abuse in 78% of the cases where domestic violence and child abuse were co-occurring in families

(McGuigan et al, 2001)

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This study was conducted with a large sample of 2,544 mothers of first-born children who participated in a Healthy Start home visitation program designed to prevent child abuse among higher risk families.

Findings indicate that domestic violence during the first six months of a child's life is significantly related to physical abuse, psychological abuse, and neglect up to a child's fifth year.

Among home visited families, domestic violence occurred among 38% of the cases of confirmed child abuse.

McGuigan WM, Pratt CC. The predictive impact of domestic violence on three types of child maltreatment. *Child Abuse & Neglect*. 2001;25:869-883.



- Battered mothers may be more likely than others to use some type of aggression against their children but are less likely to do so when they are safe (Edleson et al. 2003)



- Battered mothers appear to have greater stress than non-battered women
- However, this stress does not always translate to diminished parenting

(Holden and Ritchie, 1991,
Holden et al., 1998)



Edleson JL, Mbilinyi LF, Shetty, S. Parenting in the context of domestic violence. San Francisco, CA. 2003; Judicial Council of California.

Holden GW, Ritchie KL. Linking extreme marital discord, child rearing, and child behavior problems: Evidence from battered women. *Child Development*, 1991; 62, 311-327.

Holden, Stein, Ritchie, Harris, Jouriles, Children exposed to marital violence: Theory, research and applied issues, 1998 pp. 289-334.

Some mothers who face severe stress may compensate for violent events by offering increased nurturing and protection of their children

(Levendosky et. Al , 2003)

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Levendosky AA, Huth-Bocks AC, Shapiro DL, & Semel MA. The impact of domestic violence on the maternal-child relationship and preschool-age children's functioning. *Journal of Family Psychology*, 2003; 17, 275-287.



Most
Consistent
Protective
Factor for
Children
Exposed to
Domestic
Violence

Children's emotional recovery from exposure to DV depends more on the quality of their relationship with the nonbattering parent than any other single factor



(Bancroft & Silverman, 2002)



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Module 7

Strengthening mother-child bonding is a key strategy for helping children exposed to violence that fits well with home visitation programs' emphasis on building relationships and promoting healthy parenting skills.

Bancroft L, Silverman J. The Batterer as Parent. 2002. Sage Publications, Thousand Oaks, California.

Ways That Violence May Affect a Mother's Parenting

- Letting children make the rules
- Unable to pay attention
- Unable to control anger
- Feeling stressed and tired
- Afraid to discipline

Source: A Kid is So Special (KISS)

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Notes to Trainer: This slide provides examples of how victimization can negatively impact a mother's parenting skills. This slide is adapted from a worksheet that is designed for mothers to review and discuss with a domestic violence advocate during home visits. This tool can be adapted for use by home visitors to help mothers understand how violence can compromise parenting skills and also help her identify things that she is doing to help her children. After each example of a potential impact of victimization on a mother's parenting, there are questions for her to consider. For example, for "Letting Children Make the Rules," there are two questions to consider:

1. Have there been times when you have given in to the children—let them get away with things because you feel guilty about what was occurring in your relationship?
2. Have there been times when you have not disciplined or corrected the children to make up for the way the batterer has disciplined them?

This information, including the worksheet for mothers, is from the "Understanding Together" workbook that is part of the KISS resources that were previously noted

Pennsylvania Coalition Against Domestic Violence. A Kid is So Special (KISS). 2008. www.pcadv.org



Desiree Video Clip



The following video clip shows home visitation programs partnering with domestic violence advocates to better serve mothers and their children.



Estimated Activity Time: 10 minutes to watch video and 10 minutes for discussion

Discussion questions to ask after watching this video clip include:

1. What do you think about the partnership between the advocate and the home visitor?
2. Do you think that their working together made a difference with the case presented? Why or why not?
3. Are there some other questions that they should have been asked?
4. How many of you have ever worked with a local DV advocacy program?
5. Final thoughts about what you saw? Doable? Concerns?

(Script for mothers) Reassure your children and tell them that:

- You will take care of them the best you can
- You love them unconditionally
- You will help them make a plan to be as safe as possible



Moms can:

- Be willing to talk about the violence
- Respect their child's feelings
- Acknowledge that these feelings are okay
- Help their child to find the words to talk about their feelings
- Be prepared to hear things that may be painful



(Baker and Cunningham, 2004)



Baker L, Cunningham A. Helping Children Thrive: Supporting Women Abuse Survivors as Mothers. 2004. www.lfac.on.ca

The Amazing Brain Series

- Developed for parents
- 5th grade reading level
- Six key factors about early brain development and what children need



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This booklet, part of the Amazing Brain Series developed by the Institute for Safe Families (www.instituteforsafefamilies.org), is a resource designed for parents. The information provided in the booklet can help parents to understand how violence affects early brain development and may lead to predictable physical, mental, and behavioral problems. The booklet includes strategies that parents can use to support their children such as telling children that the violence is not their fault and asking a child what they are most worried about. A key message is also that we can help our brains to heal as adults. Six key concepts in this Amazing Brain booklet are:

1. Trauma such as exposure to violence can affect how the brain organizes and develops
2. Trauma interferes with learning
3. Children can develop posttraumatic stress disorder (PTSD) due to exposure to violence
4. Trauma leads to other health problems
5. You can make a difference
6. It is never too late to change our brains!



A Kid Is So Special (KISS)

- Series of booklets developed by the Pennsylvania Coalition Against Domestic Violence
- These interactive booklets are designed to strengthen mother/child bonds
 - “Growing Together” discusses child development
 - “Playing Together” includes information on what a parent can do when there is hurting at home



Notes to Trainer: The KISS booklets are provided in PDF format on the DVD provided with this training resource manual.

Copies can also be purchased by contacting Jo Sterner at the Pennsylvania Coalition Against Domestic Violence (PCADV) at 800-537-2238

Helping Children Thrive

Supporting Women Abuse Survivors as Mothers

Section for service providers includes:

- working with mothers in shelters
- how abusers parent
- 10 principles for service delivery

Section for women includes:

- parenting tips
- how abuse affects parenting
- strategies to strengthen the mother-child bond

(Baker and Cunningham, 2004)

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Notes to Trainer: This 75-page booklet can be downloaded at no cost, in English and French, at: www.lfcc.on.ca

The booklet is organized into two sections: one for service providers and one for women. A wide range of topics are covered that address issues spanning from infancy through adolescence to help service providers and mothers respond appropriately to children exposed to domestic violence.

Baker L, Cunningham A. Helping Children Thrive: Supporting Women Abuse Survivors as Mothers. 2004. www.lfcc.on.ca



Project SUPPORT

- Mothers and children leaving a domestic violence shelter received weekly home visits
- Home visits focused on improving social support and mothers parenting skills

Two years after the intervention:

- Children had a reduction in clinical levels of conduct problems
- Mothers less likely to use aggressive child management strategies
- Mothers less likely to return to their abusive partners

(McDonald, Jouriles, & Skopp, 2006)



Notes to Trainer: This as an important partnership between home visitation and domestic violence programs.

Ask participants for a show of hands to see if they currently use shelter partnership as a way to enroll women in your home visitation program.

- In this randomized, controlled trial, home visits were provided by a therapist and graduate student team for up to eight months after the mother and child(ren) left the domestic violence shelter
- The median number of home visits was twenty-three
- The prevalence of conduct problems was 15% among children (ages 4 to 9 years old at the start of the study) who received the intervention compared to 53% among children in the control group. Children in the control group received “usual care.”
- Aggressive child management strategies were defined as slapping, hitting, and spanking.

McDonald R, Jouriles EN, Skopp NA. Reducing Conduct Problems Among Children Brought to Women’s Shelters: Intervention Effects 24 Months Following Termination of Services. *Journal of Family Psychology*. 2006;20(1):127-136.

Module 8: Childhood Exposure to Domestic Violence and Its Impact on Parenting



Childhood Exposure to Domestic Violence and Its Impact on Parenting



Estimated Module Time: 45 minutes

Training Outline

- Learning objectives
- Information on the effects of violence on parenting
- Past exposure to violence and resiliency
- Universal education with safety card
- Video clip and role play with safety card

Overview

The following slides introduce the issue of adults' childhood experiences with violence. This topic will be addressed in the home visitor video clip and role play. We discuss the role of the home visitor in talking with parents about their childhood experiences, using the *Loving Parents*, *Loving Kids* safety card featured in the slides.

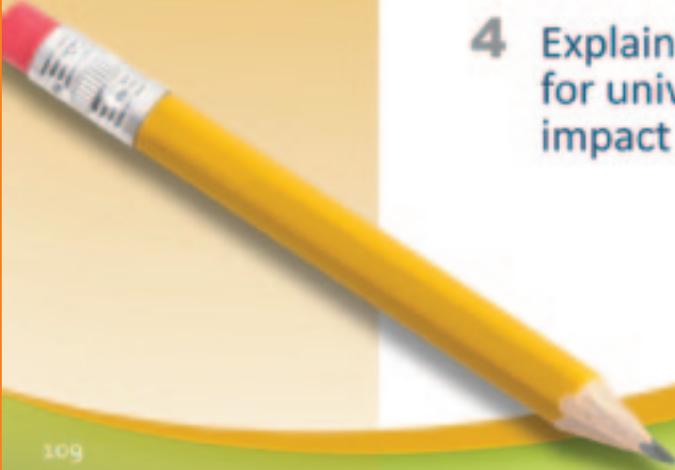
Acknowledge that parenting is personal, subjective and can be difficult—especially if there is a history of violence or current violence.

Explain how talking with parents about their experiences as children can be a platform for discussing safe homes, safe strategies for caring for children, and what it means to be in a healthy relationship.

Remind home visitors that parents who seem uncaring or neglectful—may not know another way based on their life experiences. If we believe change can happen—they are more likely to believe it too.

Learning Objectives

- 1 List two ways that violence may affect a mother's parenting.
- 2 Describe how a parent's childhood exposure to violence can impact her parenting.
- 3 Describe the difference between universal education and assessment with clients.
- 4 Explain how the safety card can be used for universal assessment to discuss the impact of violence on parenting.



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Notes to Trainer: Begin by introducing the learning objectives for this module and then review the slides on the impact of violence on parenting and resiliency.





Ways that Exposure to Violence Can Impact Parenting

Feeling out of control

Flooding/Triggering

Feeling Overwhelmed

Shame/Anxiety



Case Study

Exercise Activity Time: 10 minutes

Notes to Trainer: Read the case study below aloud to participants.

“Stella is a survivor of childhood exposure to domestic violence and childhood sexual abuse by her father. Prior to having her son (planned pregnancy) at age 23, she had undergone therapy for her abuse, taken classes on the subject, and felt she had ‘dealt’ with her issues.

When her son is about 6 months old, she stops bathing him in the kitchen sink and moves him to the regular bathtub. As she puts him in the water, she has a flashback to her own abuse as a child that occurred in the bathroom. Her hands and feet get numb, she hyperventilates—can’t catch her breath, starts crying—all the while realizing that her helpless baby could drown if she doesn’t get him out of the tub right now. She pulls him out—and later that evening tells her husband that he has to bathe the baby in the tub from now on.

Stella was totally surprised by what happened, nothing could have prepared her for it, and it came from a place inside her that she didn’t know was there.”

Questions for the audience:

1. Do you think she told her pediatrician or doctor about what happened the first time she tried to give her baby a bath?” (The audience will probably say no; if they do not respond “no”, you can advise the audience that she did not tell her pediatrician).
2. Why do you think that she did not tell her pediatrician? (Examples of responses will probably include that she was worried that her baby would be taken away by social worker and she would be seen as unfit as a mother).
3. Did she tell friends or family? (The audience will probably respond that she may be afraid to tell her family depending on whether they know about the abuse she experienced, that she was ashamed to tell her friends etc.)
4. Then ask: “Why did I share this case study with you?” (Explain that the goal of this case study and discussion is to recognize the important role of home visitors in identifying issues that otherwise may not be addressed. Mothers may not feel like talking about these issues from their past abuse unless a safe space is created for them to do so. Home visits can provide the opportunity, when it is safe to do so, to problem solve and develop a plan for how to support mothers and address triggers that may occur).

- Only a third of abused children have grown up to be abusive parents. (Kaufman et al, 1987; Kaufman et al, 1993)
- Number one factor present among those who broke the cycle of abuse: empathy for self and others. (Higgins, 1994; Steel 1997)

Kaufman, J., and E. Zigler, 1987, "Do Abused Children become Abusive Parents?" *American Journal of Orthopsychiatry* 57(2): 186-192

Kaufman, J., and E. Zigler, 1993, "The Intergenerational Transmission of Abuse is Overstated." In *Current Controversies in Family Violence*. Edited by R. J Gelles and D. R. Loseke, Newbury Park, CA: Sage Publications.

Higgins, Gina O'Connell (1994) *Resilient Adults: Overcoming a Cruel Past* (San Francisco: Jossey-Bass)

Steele, Brandt F. (1997), "Further Reflections on the Therapy of Those Who Mistreat Children," in Mary Edna Helfer, Ruth S. Kempe, and Richard Kempe, and Richard D. Krugman, eds., *The Battered Child*, 5th addition (Chicago: University of Chicago Press), Chapter 26.

Discussing childhood exposure to violence with parents can be a way to discuss healthy relationships, parenting and the impact of violence on health and emotional well-being from infancy to adulthood.



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When talking to moms about childhood exposure to violence we recommend universal education rather than direct assessment.

Why?

Because disclosure of childhood exposure is not the goal—making her aware that she might have unexpected triggers and a plan for what to do is the goal.

Notes to Trainer: Clients may not be ready to disclose past experiences of childhood victimization or exposure to violence. By using a universal education approach, you are planting a seed for clients to recognize that adverse childhood experiences can influence their parenting skills and how they react to stressful situations as adults.



Use the *Loving Parents, Loving Kids* Safety Card

What About Your Childhood?

- ✓ Did you (or your partner) see your mom hurt (beat up) by your dad or her boyfriend?
- ✓ Did you (or your partner) experience unwanted sexual touching by someone in your family?
- ✓ Did you (or your partner) have injuries or live in fear of being hurt by someone in your family?

If you answered *YES* to *ANY* of these questions you are not alone. Talking about these experiences with your home visitor or a friend can help.



Notes to Trainer: Hand out *Loving Parent, Loving Kids* safety cards (order at www.FuturesWithoutViolence.org/health) to participants.

Educating Mothers About Steps to Take When Triggered

Use the *Loving Parents, Loving Kids* Safety Card

Parenting is Hard Work

Parenting after being hurt by someone you know and love can make the work even harder. Many parents who were abused can be 'triggered' easily, quick to anger, have less patience and have more anxiety.

These are learned responses to what previously happened to you, but there are strategies to make it better:

- If you feel frustrated, gently place the baby in the crib while you catch your breath in the next room.
- If you feel unsure about your partner's ability to handle their frustration with the baby, don't leave the baby alone with them.
- Find a safe person that you can call to take a break if you are frustrated with your baby and call your home visitor for support.



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Ms. Macon Home Visitor Video Clip



Providing Universal Education on Childhood Exposure to Violence



Estimated Activity Time: 10 minutes to watch video and 10 minutes for discussion

Notes to Trainer: Show the video clip of the home visitor talking to a client about the *Loving Parents, Loving Kids* safety card (Ms. Macon, Tiffany and Richie: Home Visitation and the Impact of Childhood Exposure to Violence on Parenting).

Then discuss the video clip. Questions to ask include:

- Was the home visitor able to build rapport with the client?
- What did you think about the way Ms. Macon offered universal education to Tiffany about childhood exposure to violence? Did it feel judgmental?
- Did the client feel like she/he was being judged? Did the home visitor make the client feel comfortable when discussing childhood exposure to violence?
- Could discussing childhood exposure to violence with the client create the opportunity to also ask about domestic violence and/or discuss healthy relationships?
- How did Ms. Macon handle Richie coming into the picture? What do you think about the idea of educating both fathers and mothers about the impact violence can have on their parenting?



Role Play with Safety Card



Notes to Trainer

- Ask participants to form groups of three with each person taking one of the following roles: home visitor, client, and observer.
- Allow five minutes for the role play and 5-7 minutes for discussion.
- Read the following information for this role play:

Your client is a 19-year old mother of a newborn infant and the discussion is about childhood exposure.

The home visitor should use the *Loving Parents, Loving Kids* safety card to discuss childhood exposure to violence with this mother by focusing on the following two panels on the card: “What About Your Childhood?” and “Parenting is Hard Work.” If you are the home visitor, your goal is to use the card to introduce the concept that childhood exposure to violence can affect parenting, discuss possible steps that your client can take if she is feeling out of control or triggered by something happening with her baby, and point out the helpline phone number that is included on the safety card.
- Advise observers to note what the home visitor said that worked well.
- Ask participants who role played observers:

How did the home visitor introduce the safety card? Did she/he make the discussion comfortable? What would you have liked to see more of?
- Ask participants who role played as clients:

How did you feel? What would help you to feel more comfortable talking about this?
- Ask participants who role played home visitors:

Were you comfortable talking about the card panels? If not, what did you wish you had more of to make this work better for you?





Module 9: Fathering After Violence



Fathering After Violence



Module 9

Estimated Module Time: 30 minutes

Training Outline

- Learning objectives
- Characteristics of parenting by men who batter
- Fathering after domestic violence initiatives
- Something My Father Would Do DVD
- Resource on parenting after violence

Overview

Men who perpetrate domestic violence often have unhealthy parenting patterns that cause further harm to children who may already be traumatized from witnessing violence. This module covers interventions that promote empathy within fathers by educating them about how violence affects their children. These interventions have shown success with some fathers in reducing violent behaviors and improving parenting skills.

Learning Objectives

- 1** List three unhealthy parenting traits of men who are abusive to their partners.
- 2** Identify one potential positive outcome of educating men about the impact of domestic violence on children.
- 3** Describe a resource that addresses fathering after domestic violence.



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Notes to Trainer: Read the learning objectives aloud.



- Many men who have used violence grew up in abusive households and have lived through the cycle of violence. (Silverman and Williamson, 1997)
- Many mothers who have suffered abuse want their children to have safer and healthier contact with their fathers. (Bent-Goodley and Williams, 2007)



Bent-Goodley TB. Health Disparities and Violence Against Women Why and How Cultural and Societal Influences Matter. Trauma Violence Abuse. April 2007 vol. 8 no. 2 90-104.

Silverman JG, Williamson GM. Social ecology and entitlements involved in battering by heterosexual college males: contributions of family and peers. Violence and Victims. 1997;12(2):147-165.

- Controlling
- Very strict discipline—more likely to use physical punishment
- Under-involved
- Undermining and/or interfering with mother’s parenting
- Using the children to meet their needs
- Limited sense of age appropriateness

Notes to Trainer: As we learn more about the effects of exposure to violence on children, we are also learning more about how being abusive in a relationship affects parenting. Researchers and service providers have observed how fathers who perpetrate domestic violence often parent differently. This list describes some of the negative parenting styles that abusers may use. This information is from a resource called “Parenting After Violence” which can be downloaded at www.instituteforsafefamilies.org. Examples of negative parenting styles are provided below:

- **Controlling:** Controlling behavior is a hallmark of domestic violence and usually extends to the children; never allowing a child to make any choices can make them feel helpless.
- **Very strict discipline and physical punishment:** There can be many negative consequences of using physical discipline; these experiences can reinforce that it is acceptable to hit and hurt people whom you love.
- **Undermining and/or interfering with mother’s parenting:** Examples include criticizing the mother in front of the children, teaching the children to put their mother down and call her names, telling children that they do not have to do what their mother asks them to do.
- **Using the children to meet their needs:** Examples include asking children to report back about what their mother is doing, who she talks to, or where she goes.
- **Limited sense of age appropriateness:** Abusers often have unrealistic expectations of their children, do not understand age-appropriate behaviors, and use inappropriate discipline methods.

- Understanding the effects of domestic violence on their children can be an important motivator for abusive fathers to change their violent behavior (Donovan and Paterson, 1999)
- Positive involvement by a father figure can be very beneficial to children's development (Dubowitz et al, 2001)



Giving men more opportunities for change and healing is an essential component to end violence against women and children.

Donovan RJ, Paterson D, Francis M. Targeting male perpetrators of intimate partner violence: Western Australia's "Freedom from Fear" campaign. *Social Marketing Quarterly*. 1999;5(3):128-144.

Dubowitz H, Black MM, Kerr MA, Hussey JM, Morrel TM, Everson MD, Starr RH. Type and Timing of Mothers' Victimization: Effects on Mothers and Children. *Pediatrics*. 2001;107(4):728-735.

- There are programs that are designed to improve the parenting skills of men who batter
- These programs focus on the safety of the mother and children as the first priority



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Notes to Trainer: Guiding principles for fathering after violence programs include:

- That the safety of women and children always comes first
- That this work must be informed by the experiences of battered women and children
- Critical awareness of cultural context in which parenting occurs
- Abuse is a deliberate choice and a learned behavior that must be unlearned
- Working with fathers is an essential piece of ending violence against women and children
- Work with fathers must embrace notions of non-violence broadly
- Service coordination is essential

Examples of fathering after DV programs include:

- Domestic Abuse Project, Minneapolis, MN
- Child Witness to Violence Project, Boston, MA

Something My Father Would Do: Overcoming Legacies of Family Violence

- 15-minute DVD features stories of three men who grew up with abusive fathers and how they grappled with their own choices as fathers



- Includes discussion questions for general audiences and questions to ask when working with men who batter



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Notes to Trainer: Review the DVD before the training and consider showing at least one of the men's stories and asking some of the discussion questions below:

QUESTIONS

- What is your first impression about this story?
- What did you like the best and least about this story?
- What does this story tell you about fatherhood and violence?
- What does this story tell you about the effects of violence on children? How does domestic violence affect children across the lifespan?
- How do you think culture may affect this man's life choices?

**Module 10: Preparing Your
Program and
Supporting Staff
Exposed to Violence
and Trauma**



Preparing Your Program and Supporting Staff Exposed to Violence and Trauma



Module 10

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Module 10

Estimated Module Time: 20 minutes

Training Outline

- Learning objectives
- Brainstorming session on strategies to enhance home visitors' safety
- Secondary traumatic stress
- Handout on common reactions to working with trauma
- Strategies for home visitors and program managers
- Organizational self-assessment tool

Overview

Working with clients who experience trauma can affect the caregiver/service provider, creating secondary traumatic stress. This module reviews personal safety and self-care strategies for caregivers and policies that managers can implement to support their staff.

The subsequent slides can be used as a large group brainstorming session to ask participants what they do to enhance their safety during home visits, especially when they suspect or know that domestic violence is occurring in a household.

Review the explanation of secondary traumatic stress and acknowledge that personal experiences with violence can impact how home visitors respond to clients experiencing violence and vulnerability to secondary traumatic stress. Then provide the handout on common reactions to caring for survivors of trauma and give participants a few minutes to review the handout.

Home visitors face unique challenges and risks when working with families who are experiencing domestic violence. Home visitors may see things while visiting clients in their homes that other service providers working with the same family are not aware of such as escalating tension, threatening behaviors, and signs of violence (broken furniture, hole in the wall etc.). Because a home visitor may be in the home when physical violence erupts, it is essential that home visitation programs have a safety protocol for staff to follow when they are working with families experiencing domestic violence.

Learning Objectives

- 1 Name two strategies to enhance personal safety for home visitors who are working with families experiencing domestic violence.
- 2 Name two common reactions when caring for survivors of trauma.



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Notes to Trainer: Read the learning objectives aloud.



- Meet with the client at the office if the situation does not feel safe
- Establish check-in times with the home office
- Park with the front of your vehicle pointed towards exit
- Observe and listen before entering a household
- Do not enter the household until you see the client at the door
- Position yourself near the door/exit in the household
- Have emergency numbers programmed into your cell phone and set on auto-dial



Estimated Activity Time: 10 minutes

Notes to Trainer: Other service providers that work with families experiencing domestic violence and have contact with families in their homes may have protocols and safety strategies that could be helpful for home visitors.

Inviting service providers such as police officers and child protection workers to do a brown bag lunch training provides the opportunity for cross-training and building partnerships between agencies that are often working with the same families.

These safety strategies are discussed along with other practical lessons learned about working with domestic violence within the context of home visits in the following publication:

“Chamberlain L. Addressing Domestic Violence within the Context of Home Visitation”

This is a great topic for brainstorming. Ask participants what they do to stay safe during home visits, especially when they have concerns about a particular situation. Create a list of strategies that the audience recommends (working together as pairs to do home visits, wearing slip on shoes that can be slipped into quickly, keep car keys easily accessible, etc.)

Home visitors have emphasized how important it is to look for behavioral clues and to always be aware and to not get too comfortable that you ignore warning signs that it may not be a safe situation.

Chamberlain L. Addressing Domestic Violence within the Context of Home Visitation. *Journal of Emotional Abuse*, Volume 8 (1/2): 2008; available online at <http://jea.haworthpress.com>

Secondary Traumatic Stress

Secondary traumatic stress, also referred to as vicarious trauma, burnout, and compassion fatigue, describes how caring for trauma survivors can have a negative impact on service providers.



Handout: Secondary Trauma Handout

- Lifetime exposure to violence is common among home visitors
- Working with clients who are experiencing domestic violence can trigger painful memories and trauma for staff
- A personal history of exposure to violence increases the risk of experiencing secondary traumatic stress

Personal Strategies to Prevent Traumatic Stress

- Identify resources available through employee assistance/human resource programs
- Implement debriefing sessions and periodic case reviews
- Develop plans for how to respond to different situations that are stressful for staff
- Offer stress management training to staff
- Implement policies to maintain a secure and violence-free work environment

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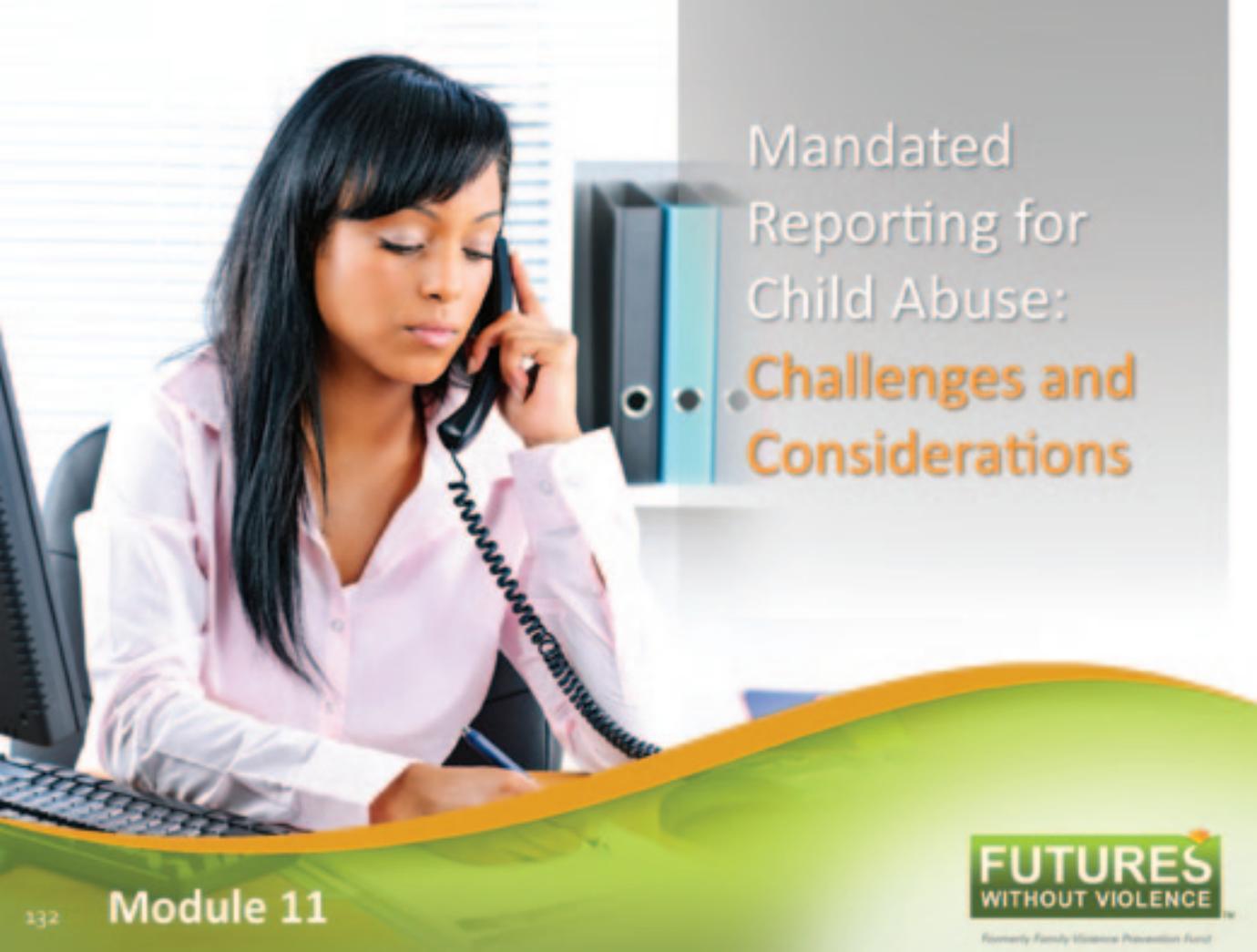
Notes to Trainer: *Workplaces Respond to Domestic and Sexual Violence: A National Resource Center*, makes it easier than ever for employers to adopt vitally important policies to protect employees from domestic and sexual violence. The new *Center* was formed by a partnership of seven national organizations led by Futures Without Violence, and funded by the Justice Department's Office on Violence Against Women (OVW). For more information, visit: www.workplacesrespond.org

Encourage program managers to implement strength-based practices so that only staff who have had training on domestic violence, who are comfortable with doing screening, and who are prepared to respond appropriately to disclosures are doing assessment with clients.

- Instrument designed to help agencies create trauma-informed, supportive work environments
- Checklist format for organizations to evaluate:
 - Training and education
 - Support and supervision
 - Communication
 - Employee control and input
 - Work environment
- Self-assessment handout for employees



Module 11: Mandated Reporting for Child Abuse: Challenges and Considerations



Mandated Reporting for Child Abuse: Challenges and Considerations



Estimated Module Time: 20 minutes

Training Outline

- Learning objectives
- Key considerations
- Supporting mothers
- Resource

Overview

This module offers a brief introduction to a complex topic that should be part of continuing education for home visitors. While all states have mandated reporting for child abuse, requirements and procedures vary considerably by county and state. It is important for trainers to be aware of local response practices. Trainers should consult with their local child protection agency before doing any training to learn the basics and have referral information for further training and consultation available.

If time allows, this module provides an excellent opportunity for a guest speaker to talk about mandated reporting for child abuse in your jurisdiction.

For more information on state laws and regulations go to: www.FuturesWithoutViolence.org to see a compendium of state statutes and policies on DV and healthcare.



Learning Objectives

- 1 Describe two key considerations for addressing child maltreatment when domestic violence is also present.
- 2 Identify two strategies to support and involve mothers when making a mandated report to child protective services.
- 3 Explain the importance of working with child welfare workers and other community partners to learn more about procedures and practices in your community.



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Notes to Trainer: Read the learning objectives aloud.



- Batterers may threaten that they will get sole custody if their partner seeks a divorce
- Moms may be charged with failure to protect
- Cross-training with child welfare workers is essential to understand how batterers may manipulate systems and service providers in ways that can further endanger battered women and their children
- Promoting safety and keeping children in the care of their non-battering parent whenever possible are core principles in intervention



Notes to Trainer: Encourage home visitors to request and program managers to arrange cross-training with their local/regional child protection agencies. It is very helpful to include domestic violence advocates in these trainings to identify strategies for collaboration on cases where domestic violence and child maltreatment are co-occurring. Periodic brown bag lunches or other opportunities for home visitors, child welfare workers and domestic violence advocates to meet and brainstorm about best practices can lead to a more coordinated response to domestic violence and child maltreatment.

- Inform your client of your requirement to report
- Explain what is likely to happen when the report is made
- Ask your client if she is willing to call or meet with an advocate to develop a safety plan in case of retaliation
- Maximize the role of the client in the process



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Notes to Trainer: Before you do training, learn about the reporting requirement for your county. Information that you will need to know includes:

- Who is required to report?
- What must be reported?
- To whom is the report made?
- What are the likely outcomes of calling the police or child protective services?
- What are the safety considerations you can address with your client?
- Are there provisions for confidentiality of reports?

Ways to involve the client in the process include asking if she would like to be present when you make the report if that is safe to do and keeping her informed about the process.

Encourage participants to contact local domestic violence program/shelter and domestic violence coalitions in their state to learn about additional training, consultation on particular cases, and resources for their clients.

Remind participants that making a report can never substitute for the important care they provide.



Example:
(check your
county/state
specific
requirements)

“Everything you share with me is confidential. This means what you share with me is not reportable to child welfare, INS (Homeland Security) or law enforcement. There are just two things that I would have to report-if you are suicidal, or your children are being harmed. The rest stays between us and helps me better understand how I can help you and the baby. ”



IMPORTANT TIP: Before you ask about anything that the client may be worried about being reportable—(INCLUDING immigration status) always discuss limits of confidentiality:

(This is a good example of something you might consider using on the top of a self administered form or put on the top of the form the staff fill out so they don't forget).

It is important to research what the law and requirements are in your county/state regarding reporting domestic violence prior to conducting any training. You can add additional slides to this module about what is required in your area and you should be prepared for questions on this topic and offer contacts for additional information and questions that you may not be able to answer.

Key
Partnership:
Develop a
Memorandum
of
Understanding
with your
Local Child
Welfare
Program

Unless your state has a law that requires mandated reporting for children who are exposed to domestic violence, reporting all cases of children exposed to domestic violence is discouraged. Such practices often have unintended consequences that prevent mothers from seeking help and may cause greater risk to women and children. In addition, children may be unnecessarily removed from their mother's care.



Module 12: Closing and Post-Training Survey

Closing and Post-Training Survey



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Module 12

Estimated Module Time: 10 minutes

Training Outline

- “Where am I” exercise
- Post-training survey

Overview

If time allows, you can solicit feedback from participants as you transition to the next slide on the “Where Am I” exercise. Ask participants to reflect back to the “Where Am I?” exercise that they completed at the beginning of the training and think about how this training may have impacted their comfort level with addressing domestic violence during home visits.

Exercise:
"Where Am I
Now?"



- On the left end of the meter is "not at all comfortable"
- On the right end of the meter is "very comfortable"
- Write down where you are now and compare it to what you wrote down this morning

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Notes to Trainer: Ask participants if anyone would like to share their observations about any impact that the training has had on their level of comfort with addressing domestic violence with clients.

A key strategy for effective trainers is always having the last word at a training. Complete the discussion and then provide your closing comments about what you want the participants to take home from this training.

For questions about how to introduce and facilitate training vignettes and for other free technical assistance and tools including:

- Posters
- Safety cards
- Guidelines on Reproductive Coercion

Contact The National Health Resource Center on Domestic Violence, a project of Futures Without Violence:

- Visit: www.FuturesWithoutViolence.org/health
- Call Toll-free: **888-Rx-ABUSE (792-2873)**
800-595-4889 TTY
- Email: health@FuturesWithoutViolence.org





Please complete
the Post-Training
Survey

Thank You!



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Notes to Trainer: Hand-out the post-training survey for participants to complete and provide your contact information for any questions and follow-up.

Remind participants that their responses are confidential.

Share your closing thoughts and thank participants for their time, expertise, and dedication to making a difference for the families and communities they work with.



Appendices

PRE-TRAINING SURVEY FOR HOME VISITORS

Thank you very much for joining us!

As you know, exposure to violence is associated with multiple poor health outcomes for children and their families, and is likely to impact the lives of many of the families you work with and support. We are developing ways to improve how we talk about domestic violence, sexual violence, and childhood violence experiences with our families.

We would like to ask you a few questions about your experiences as a home visitor talking to your clients about healthy relationships and violence in the home, and in what areas you would like to have additional training and support.

Please take a few moments to answer the following questions. Your responses will be kept confidential. You may skip any questions that you do not want to answer, and you can stop taking the survey at any time.

We would also like to contact you in a few months to find out how useful this training was to you in practice, whether you were able to use any of the components presented, and to have you reflect on additional training, resources, and supports you want to see.

We greatly appreciate your taking the time to answer these questions for us as we aim to improve the violence prevention and intervention trainings for home visitation programs.

Pre-Training Survey for Home Visitors

- 1) Have you ever had training on domestic violence (DV)?
 - A) Yes
 - B) No

- 2) Have you ever had training on how domestic violence (DV) can affect parents' health?
 - A) Yes
 - B) No

- 3) Have you ever had training on how experiencing violence during childhood (child abuse and witnessing domestic violence) can affect parents' health?
 - A) Yes
 - B) No

- 4) I feel confident that I can talk to a parent (male or female) about violence in the home and how this can affect their child's health.
 - A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree

- 5) I feel confident that I can assess for domestic violence (DV) with parents in my home visitation program.
 - A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree

- 6) I feel confident that I can talk to a parent (male or female) about how experiencing violence during childhood might affect one's parenting.
 - A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree

Pre-Training Survey for Home Visitors

- 7) I feel confident talking with my female clients about birth control including whether their partners are supportive of their using it.
- A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree
- 8) When a female client has told me that her pregnancy was unplanned, I feel confident asking if she feels her partner was trying to get her pregnant when she didn't want to be.
- A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree
- 9) I feel confident educating female clients about birth control their male partner cannot interfere with (example IUD, Implanon, Depo).
- A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree
- 10) When a female client has another pregnancy shortly after her first baby, I feel confident asking if there is anyone who will hurt her if she doesn't do what they want with the pregnancy.
- A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree
- 11) I am comfortable helping a client needing services for DV.
- A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree

Pre-Training Survey for Home Visitors

- 12) I understand the possible implications of making a report to child welfare or law enforcement for mothers and children.**
- A) Strongly disagree
 - B) Disagree
 - C) Neutral
 - D) Agree
 - E) Strongly agree
- 13) How often are you giving your clients a safety card about domestic violence?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
- 14) How often do you review the limits of confidentiality with your clients before asking about coercion or violence?**
(i.e., based on your state's reporting laws, telling the clients what you are required to report like whether they are at risk of hurting themselves?)
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
- 15) How often do you assess for domestic violence (DV) with new clients?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
- 16) How often do you assess for domestic violence (DV) when a client tells you s/he is feeling depressed?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)

Pre-Training Survey for Home Visitors

- 17) How often do you assess for domestic violence (DV) when a client is smoking, drinking alcohol or using other drugs while pregnant?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
- 18) What are reasons that you may not address domestic violence (DV) during a home visit? (circle all that apply)**
- A) Not enough time
 - B) It's not my job or in my job description
 - C) Asking doesn't help
 - D) The partner is present for the visit
 - E) Worried about upsetting the client
 - F) Not sure what to say if they disclose an abusive/violent relationship
 - G) Afraid what would happen if they told me
 - H) Not sure how to ask questions without seeming too intrusive
 - I) Not knowing where to refer them to
 - J) Worried about mandated reporting
 - K) Have already screened them at past visit
 - L) Does not apply to my client population
 - M) Other _____
- 19) What are reasons that you may not discuss the adult clients' experiences with violence during their own childhood? (circle all that apply)**
- A) Not enough time
 - B) The partner is present for the visit
 - C) Worried about upsetting the client
 - D) Not sure what to say if they disclose a history of childhood abuse
 - E) Afraid what would happen if they told me
 - F) Not sure how to ask questions without seeming too intrusive
 - G) Not knowing where to refer them to
 - H) Worried about mandated reporting
 - I) Have already screened them at past visit
 - J) Does not apply to my client population
 - K) Other _____

Pre-Training Survey for Home Visitors

- 20) In the past 6 months, how many of your own clients have disclosed to you that they are victims of domestic violence (current as well as lifetime experiences)?**
- A) 75% or higher
 - B) 50% or higher
 - C) 25% or higher
 - D) 10% or higher
 - E) None
- 21) In the past 6 months, how many of your own clients have shared with you that they experienced childhood abuse, including witnessing violence between adult caregivers?**
- A) 75% or higher
 - B) 50% or higher
 - C) 25% or higher
 - D) 10% or higher
 - E) None
- 22) As part of your home visits, are there specific protocols about what to do when a client discloses domestic violence (DV)?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 23) As part of your home visits, are there specific protocols about what to do when a client discloses their own experiences with violence as a child (childhood abuse, witnessing DV)?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 24) As part of your home visits, are there any instructions/protocols on how to file a report to child welfare?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know

Pre-Training Survey for Home Visitors

25) As part of your home visits, are there scripted tools or written instructions on how to do safety planning with clients who disclose domestic violence (DV)?

- A) Yes
- B) No
- C) Not applicable
- D) Don't know

26) Does your home visitation program have (circle all that apply):

- A) Brochures, cards or information about domestic violence (DV), and childhood exposure to violence (CEV) and parenting?
- B) Prompts inserted into intake forms to assess for DV/CEV?
- C) In-service trainings for all staff on DV/CEV?
- D) Materials on DV that are specifically targeted to teen parents?
- E) Other (please be as specific as you can): _____

27) Are educational materials available on domestic violence (DV) in the languages most commonly spoken in your program?

- A) Yes
- B) No
- C) Not sure

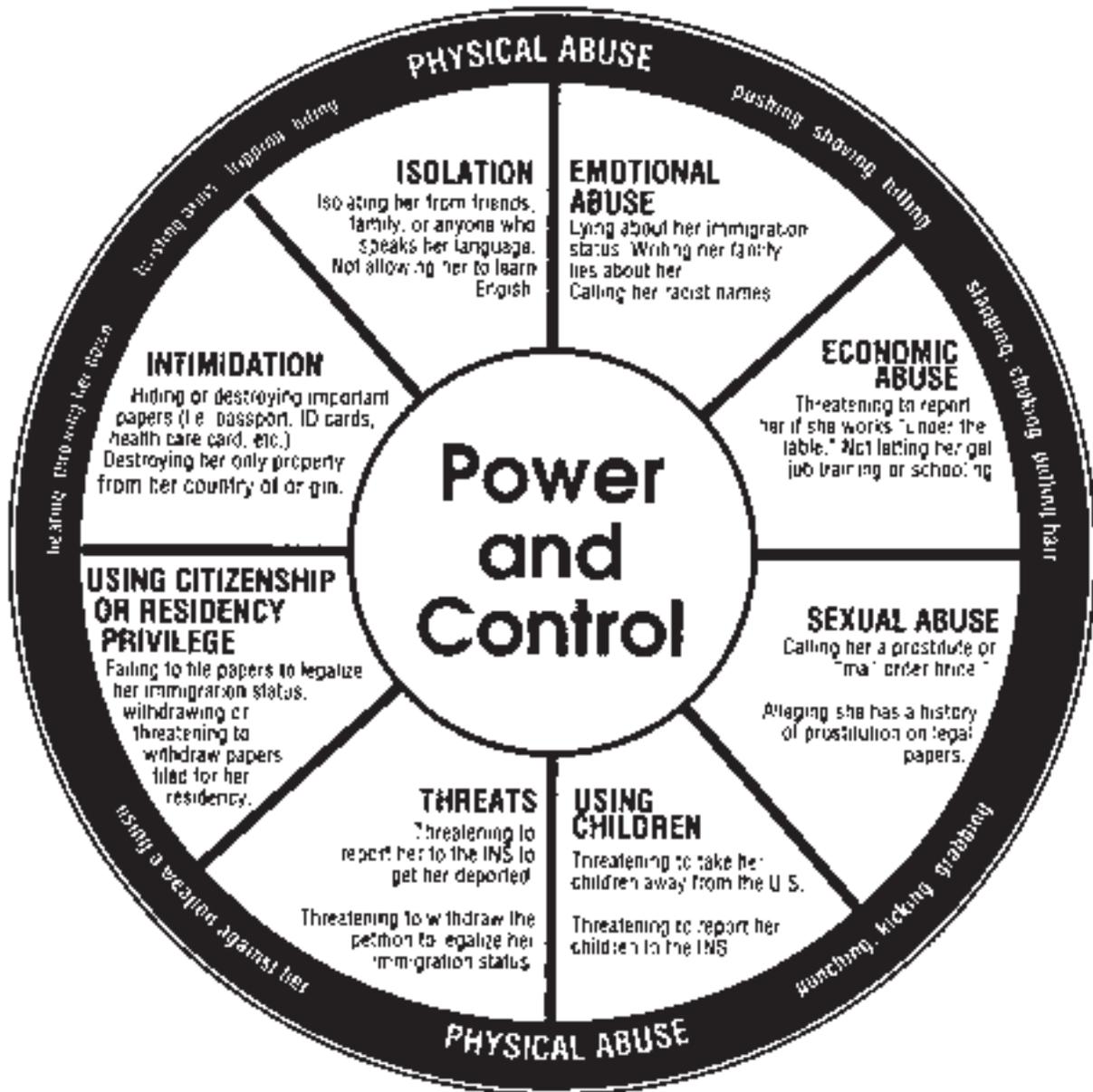
28) What support do you need to incorporate discussion of DV/CEV in all your home visits? (circle all that apply)

- A) Workshops and training sessions
- B) Protocols that include specific questions to ask
- C) List of violence-related resources and who to call with questions
- D) Case consultation
- E) Online training
- F) Other (Please specify) _____



POWER AND CONTROL WHEEL

Forms of domestic violence that women experience



This version of the Power and Control wheel, adapted with permission from the Domestic Abuse Intervention Project in Duluth, Minnesota, focuses on some of the many ways battered immigrant women can be abused.

Adapted by Futures Without Violence, www.futureswithoutviolence.org.



CULTURAL COMPETENCY

CASE STUDY

Definitions:

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural-situations.

Source: US Department of Health and Human Services. (2005). what is cultural competency? www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=11

Linguistic competence is the capacity of an organization or personnel to communicate effectively, and convey information in a way that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills, and individuals with disabilities

Source: Goode T, Jones W. (2004) Definition of linguistic competence, National Center for Cultural Competence. Washington, DC; National Center for Cultural Competence, Georgetown University Center for Child and Human Development. www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html

Case Study:

Lia, a 32-year-old woman from the Dominican Republic, is diagnosed with syphilis. She has been in the United State with her husband and four children for three years. She is pregnant and is afraid to tell her husband that she has the disease for fear that he will be angry with her. She speaks very limited English, and her primary language is Spanish. Lia decides to disclose this information to her home visitor who she is developing a trusting relationship with. The home visitor is from a different cultural background and does not speak Spanish. Lia is reluctant to talk about her problem but nervously tries although communication between the home visitor and Lia is very poor because Lia is embarrassed that she does not speak English very well and is afraid to share her feelings. The home visitor knows that Lia's husband is quite fluent in English and asks her if she should come back when he is home so that they can discuss where they can go for treatment and talk about using condoms. Lia becomes very quiet and says that she does not want to talk about this again.



EXAMPLE OF THE HEALTHY MOMS, HAPPY BABIES SAFETY CARDS

(ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.FuturesWithoutViolence.org/health.

Plan de Seguridad

Si su pareja la está lastimando, usted no tiene la culpa. Usted merece estar segura y ser tratada con respeto.

Si su seguridad está en riesgo:

1. Llame al 911 si corre peligro inmediato.
2. Prepare un paquete de emergencia, en caso de que tenga que irse repentinamente, que incluya: dinero, chequera, llaves, medicinas, una muda de ropa, y documentos importantes.
3. Hable con su visitador domiciliario para ayuda con llamadas a líneas de asistencia locales o nacionales, para la atención de la violencia doméstica y para más información sobre planeación de seguridad.

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Tomando el Control

Referencias Pueden Ayudar

Buscando apoyo para usted y sus hijos le puede ayudar a avanzar hacia un futuro más saludable—aún el paso más pequeño es algo para celebrar.

Mientras que programas de la violencia doméstica locales y nacionales pueden ayudar con su plan de seguridad y pueden proporcionarle con referencias a refugios seguros, también ofrecen servicios para mujeres que no quieran, o no están listas para irse al refugio.

Muchos programas ofrecen:

- grupos de apoyo para mujeres y programas para niños.
- clases para fomentar su confianza, planear para su futuro, y apoyarle en la crianza de sus hijos—llame a su programa local para averiguar lo que está disponible.

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Funded by the Administration on Children, Youth and Families, U.S. Department of Health and Human Services and the Office on Women's Health, U.S. Department of Health and Human Services.

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Líneas directas nacionales pueden conectarle a los recursos locales y proporcionarle apoyo:

Para obtener apoyo gratuito, las 24 horas del día, llame:

**Línea Nacional Sobre la Violencia Doméstica
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224**

**Línea Nacional sobre el Abuso de Novios Adolescentes
1-866-331-9474**

**Línea Directa para la Atención de Casos de Violencia Sexual
1-800-656-4673**



**Mamás Sanas,
Hijos Felices:
Creando Futuros Sin Violencia**

Safety Planning

If you are being hurt by a partner it is not your fault. You deserve to be safe and treated with respect.

If your safety is at risk:

1. Call 911 if you are in immediate danger.
2. Prepare an emergency kit in case you have to leave suddenly with: money, checkbook, keys, medicines, a change of clothes, and important documents.
3. Talk to your home visitor for help calling the local or national domestic violence hotline for additional information on safety planning.

Taking Control Back

Referrals Can Help

Getting support for yourself and your children can help you move toward a healthier future—even the smallest step is something to celebrate.

While local and national domestic violence programs can help with safety planning and provide referrals to safe shelters, they also provide services for women who may not want or be ready to go to shelter. Many programs have:

- drop-in support groups for women and programs for children.
- classes to build confidence, plan for the future and support your parenting—call your local program to find out what is available.



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National hotlines can connect you to your local resources and provide support:

For free help 24 hours a day, call:

**National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224**

**Teen Dating Abuse Hotline
1-866-331-9474**

**Rape, Abuse, Incest,
National Networks (RAINN)
1-800-656-HOPE (1-800-656-4673)**



**Healthy Moms,
Happy Babies:
Creating Futures without Violence**



How is it going?

All moms deserve healthy relationships. Ask yourself:

- ✔ Do I feel respected, cared for and nurtured by my partner?
- ✔ Does my partner give me space to be with friends or family (or to take breaks from the baby)?
- ✔ Does my partner support my decisions about if or when I want to have more children?

If you answered YES to any of these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, longer life, and better outcomes for children.

On Bad Days?

Is my relationship unsafe or disrespectful? Ask yourself:

- ✔ Does my partner shame or humiliate me?
- ✔ Does my partner threaten me, hurt me, or make me feel afraid?
- ✔ Does my partner force me to do sexual things I don't want to?
- ✔ Does my partner threaten to hurt my children or my family?

If you answered YES to any of these questions, you don't deserve to be hurt and your home visitor can support you and connect you to helpful programs.

Know Your Rights

What does your home visitor have to report to the authorities?

- Child abuse and neglect.
- A few states require that domestic violence must be reported to the police, others do not.
- A few states have laws that view domestic violence and/or substance abuse as child abuse and this can result in a report to child welfare.

You have the right to know what your home visitor is required to report. Ask your home visitor about what is reportable and to whom.

Coping Strategies

How is your health, how are you coping? Ask yourself:

- ✔ Do I feel so sad I can't get out of bed? Or take care of the baby?
 - ✔ Am I smoking more to try and calm myself?
 - ✔ Am I using alcohol, prescription medications, or other drugs to make the pain go away?
 - ✔ Do I ever feel so sad that I have thoughts of suicide?
- If you answered YES to any of these questions, it may be the result of chronic stress. Talk with your home visitor right away about how to get help.

¿Cómo le va?

Toda mamá merece relaciones sanas. Pregúntese:

- ✔ ¿Me siento respetada, cuidada, y apoyada por mi pareja?
- ✔ ¿Mi pareja me da espacio para salir con amigos o familia (o tomar descansos del bebé)?
- ✔ ¿Mi pareja apoya mis decisiones sobre cuándo o si quiero tener más hijos?

Si usted contestó SI a algunas de estas preguntas, es probable que usted está en una relación sana. Los estudios muestran que este tipo de relación lleva a una vida más saludable y larga, y mejores resultados para sus hijos.

¿Qué tal los días malos?

¿Estoy en una relación que no es segura o respetuosa? Pregúntese:

- ✔ ¿Mi pareja me avergüenza o humilla?
- ✔ ¿Mi pareja me amenaza, me lastima, o me hace sentir miedo?
- ✔ ¿Mi pareja me fuerza a hacer cosas sexuales que yo no quiero?
- ✔ ¿Mi pareja me amenaza con hacer daño a mis hijos o mi familia?

Si usted contestó SI a algunas de estas preguntas, usted no merece ser lastimada y su visitador domiciliario puede apoyarle y conectarle con programas de ayuda.

Conozca sus derechos.

¿Qué es lo que tiene que reportar su visitador domiciliario a las autoridades?

- Abuso infantil y negligencia.
- Algunos estados requieren que la violencia doméstica sea reportada a la policía, otros no la requieren.
- Algunos estados tienen leyes que consideran la violencia doméstica y/o el abuso de sustancias como abuso infantil y este puede resultar en un informe al bienestar de menores.

Usted tiene el derecho de saber lo que su visitador domiciliario está requiriendo a reportar. Pregunte a su visitador domiciliario sobre qué es reportable y a quién.

Estrategias de afrontamiento

¿Cómo está su salud? ¿Cómo está haciendo frente? Pregúntese:

- ✔ ¿Me siento tan triste que no puedo levantarme de la cama, o cuidar del bebé?
 - ✔ ¿Estoy fumando más para calmarme?
 - ✔ ¿Estoy tomando alcohol, medicamentos con receta, u otras drogas para aliviar el dolor?
 - ✔ ¿Alguna vez me he sentido tan triste que he pensado en el suicidio?
- Si usted contestó SI a algunas de estas preguntas, puede ser el resultado del estrés crónico. Hable con su visitador domiciliario inmediatamente sobre cómo obtener ayuda.

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RELATIONSHIP ASSESSMENT TOOL

Date: _____

This is a self-administered tool for clients to fill out. If the client was unable to complete this tool today, was it because other people were present in the home? Circle one: **Yes/No**

Other reason for not using tool today: _____

(Note to home visitor: Please modify this script based on your state laws. This is just a sample script.)

“Everything you share with me is confidential. This means what you share with me is not reportable to child welfare, INS (Homeland Security) or law enforcement. There are just two things that I would have to report- if you are suicidal, or your children are being harmed. The rest stays between us and helps me better understand how I can help you and the baby.”

We ask all our clients to complete this form. For every question below, please look at the scale and select the number (1-6) that best reflects how you feel.

1	2	3	4	5	6
Disagree Strongly	Disagree Somewhat	Disagree a Little	Agree a Little	Agree Somewhat	Agree Strongly

- 1) He makes me feel unsafe even in my own home..... _____
- 2) I feel ashamed of the things he does to me..... _____
- 3) I try not to rock the boat because I am afraid of what he might do _____
- 4) I feel like I am programmed to react a certain way to him _____
- 5) I feel like he keeps me prisoner _____
- 6) He makes me feel like I have no control over my life, no power, no protection _____
- 7) I hide the truth from others because I am afraid not to _____
- 8) I feel owned and controlled by him _____
- 9) He can scare me without laying a hand on me _____
- 10) He has a look that goes straight through me and terrifies me..... _____

Please turn the page and continue the survey. Thank you.

Adapted from: Smith, P.H., Earp, J.A., & DeVellis, R. (1995), Development and validation of the Women’s Experience with Battering (WEB)Scale. Women’s Health, **1**, 273-288.



Relationship Assessment Tool (page 2)

1	2	3	4	5	6
Disagree Strongly	Disagree Somewhat	Disagree a Little	Agree a Little	Agree Somewhat	Agree Strongly

- 1) Has my partner ever physically hurt me? _____
- 2) Has my partner ever forced me to do something sexual I didn't want to? _____

Thank you for completing this survey. Please give it back to your home visitor so they can complete the bottom portion.

Home visitors complete the next section:

- 1) What referrals and information were given to the client this session? (Please note, ALL clients should have been given the *Healthy Moms, Happy Babies* safety card).

(Circle all that apply)

- Social Worker/Counselor
- Domestic Violence Hotline
- Local Domestic Violence Advocate/Program
- *Healthy Moms, Happy Babies* Safety Card
- Other (please specify): _____

- 2) Did you offer safety planning? (This should happen for any score higher than 20 for pages one and two)

(Circle all that apply)

- Reviewed **Safety Planning** panel on *Healthy Moms, Happy Babies* card.
- Provided the *Safety Plan and Instructions* tool to my client.
- Provided domestic violence hotline numbers.
- Referred to domestic violence advocate for additional safety planning.
- Other (please specify): _____



Additional Client Education Sessions: Reproductive Coercion and Parenting After Violence

- 1) Question for home visitors:** When should I introduce the “What About Your Childhood” and “Parenting is Hard Work” panels of the *Loving Parents, Loving Kids* safety card?

Answer: During the 8th month/third trimester of her pregnancy or soon after the birth of the baby.

Conversation starter: “We have started talking to all our clients about this Loving Parent’s Card. These two panels are really important because they talk about how your past can affect the way you parent and give you strategies if you ever find yourself frustrated. On the back of the card is a confidential 24/7 hotline in case you are feeling like you are having a hard time with the baby and just need someone to listen.”

Date _____ Card Panels Reviewed **yes/no**

- 2) Question for home visitors:** When should I introduce the panels of the “Let’s talk Pregnancy” and “Taking Control” *Loving Parents, Loving Kids* safety card?

Answer: During the 8th month/third trimester of her pregnancy or soon after the birth of the baby.

Conversation starter: “One of the things we are talking to all our moms about is when and or if they want another baby. Sometimes this decision isn’t hers to make. I wanted to go over the ‘Let’s Talk Pregnancy’ and ‘Taking Control’ sections of the *Loving Parents, Loving Kids* safety card to see if you need any additional referrals.”

Date _____ Card Panels Reviewed **yes/no**

What referrals and information were given to the client this session? (Please note, ALL clients should have been given the *Loving Parents, Loving Kids* safety card).

(Circle all that apply)

- Social Worker/Counselor
- Child Help Hotline (on back of safety card)
- Local Domestic Violence Advocate/Program
- *Loving Parents, Loving Kids* Safety Card
- Reproductive Health Provider
- Appendix I - Birth Control Education Sheet Offered
- Other (please specify): _____



SAFETY PLAN AND INSTRUCTIONS

SAFETY PLAN

Step 1:

Safety during a violent incident. I can use some or all of the following strategies:

- A) If I have/decide to leave my home, I will go _____.
- B) I can tell _____ (neighbors) about the violence and request they call the police if they hear suspicious noises coming from my house.
- C) I can teach my children how to use the telephone to contact the police.
- D) I will use _____ as my code word so someone can call for help.
- E) I can keep my purse/car keys ready at (place) _____, in order to leave quickly.
- F) I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2:

Safety when preparing to leave. I can use some or all of the following safety strategies:

- A) I will keep copies of important documents, keys, clothes and money at _____.
- B) I will open a savings account by _____, to increase my independence.
- C) Other things I can do to increase my independence include: _____.
- D) I can keep change for my phone calls on me at all times. I understand that if I use my telephone, credit card, or cell phone, the telephone bill or phone log will show my partner the numbers that I called after I left.
- E) I will check with _____ and my advocate to see who would be able to let me stay with them or lend me some money.
- F) If I plan to leave, I won't tell my abuser in advance face-to-face, but I will leave a note or call from a safe place.

Step 3:

Safety in my own residence (some of these things can be paid for by Victim of Crime Dollars for more information www.ncjrs.gov/ovc_archives/factsheets/cvfvca.htm). Safety measures I can use include:

- A) I can change the locks on my doors and windows as soon as possible.
- B) I can replace wooden doors with steel/metal doors.
- C) I can install additional locks, window bars, poles to wedge against doors, and electronic systems etc.
- D) I can install motion lights outside.
- E) I will teach my children how to make a collect call to me if my _____ partner takes the children.
- F) I will tell people who take care of my children that my partner is not permitted to pick up my children.
- G) I can inform _____ (neighbor) that my partner no longer resides with me and they should call the police if he is observed near my residence.



Safety Plan and Instructions

Step 4.

Safety with a protection order. The following are steps that help the enforcement of my protection order.

- A) Always carry a certified copy with me and keep a photocopy.
- B) I will give my protection order to police departments in the community where I work and live.
- C) I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.

Next Step INSTRUCTIONS

Legal Considerations...

- Domestic Violence is a crime and you have the right to legal intervention. You should consider calling the police for assistance. You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Contact a local DV program or an attorney for more information.
- If you have injuries, ask a doctor or nurse to take photos of your injuries to become part of your medical record.

CALLING THE POLICE*

When someone has injured you or violated a restraining order, criminal stay-away order or emergency protective order, do the following:

- 1) Call the police at 911, if it is an emergency. Tell them you are in danger and you need help immediately. Let them know if you have a court order. If the police do not come quickly, call again and say "This is my second call." Note the time and date of your call(s).
- 2) When the police arrive, tell them only what your partner or ex-partner did. Describe your injuries, how you were injured or how he violated a restraining order, and if your partner or ex-partner used weapons. If he has violated a restraining order, show the police your order and any proof of service. Ask that the police file a report and give you a report number.
- 3) Tell the officers that the attacker will come back and beat you unless they make an arrest. If the police make an arrest and take the attacker into custody, you should be aware that he/she could be released within a few hours. You can use those hours to get to a safer place.
- 4) If you don't have a restraining order or an injunction for protection, ask the officer for an Emergency Protective Order. This is an order that may protect you until you obtain a criminal stay-away order or restraining order.
- 5) Always get the police officers' names and badge numbers. If you have trouble with a police officer, you can complain directly to the Chief of Police or to the officer's supervisor.
- 6) If the violator is arrested and taken to the police station, he/she may be charged and he/she will probably be released on bail or, in certain circumstances, without bail until the hearing. Ask that a condition of his release be that he should not come near you. This process may take from 2 to 48 hours.

Safety Plan and Instructions

- 7) If the violator is not arrested you should call the prosecutor or police department about how to follow-up with your complaint.
- 8) Keep a journal documenting what happened.



SAMPLE MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding (MOU) Between Home Visitation and Domestic Violence Programs

Background

Home visitation programs are case management programs designed for pregnant and parenting mothers of small children. These voluntary programs have been created for low-income mothers to support their parenting and infant/toddler care through health education and by providing linkages to local services. Home visitation programs help mothers with a range of issues, one of which is domestic violence. Many home visitation programs are required to screen for domestic violence and provide referrals to local domestic violence programs and national hotlines.

The goal of this MOU is twofold. The first goal is to help establish a deeper relationship between home visitation and domestic violence programs and support ‘warm’ referrals. As an example of why deeper program partnerships can make a difference in conversation with clients, we are working with home visitors so referrals are more like: “If you are comfortable with this idea, I would like to call Sherrie from Safe Haven (local DV program), she is really kind and has worked with many, many women in your shoes.” Verses—“Here is a hotline number in case you need to call.” When personal connections are made between programs it helps clients feel safer accessing support and taking action.

Some home visitation programs have already developed such relationships with their local domestic violence agency. In fact, some partnerships have made it possible for the home visitor to bring the advocate to meet with a woman as part of case management to encourage deeper participation in domestic violence advocacy services. While we recognize that not all programs have this capacity, this partnership can create an opportunity for a direct connection to a domestic violence program that she might otherwise not make.

A second goal in developing a partnership between home visitation and domestic violence services is to create opportunities to connect pregnant and parenting women to home visitation services while they are in shelter. Developing a trusting relationship with the home visitation program is a way to extend support to women beyond shelter and help her connect to case management services that would be more trauma and violence informed through a partnership between agencies.

This recommendation comes with caveats. Of course it would be essential that home visitation staff signed a confidentiality agreement if they were to come to the shelter in the same way advocates do and promise not to reveal the location of the shelter and the location of the mother and her children.



The parties listed above and whose designated agents have signed this document agree that:

- 1) _____ (home visitation program) and _____ (domestic violence program) will meet with each other once per year to understand the services currently provided by their respective programs and review referral policies between agencies.
- 2) When domestic violence is identified by home visitation, _____ (home visitation program) will review advocacy services available and provide referral to _____ (domestic violence programs).
- 3) Any home visitor assigned to providing services to pregnant or parenting women at the shelter will complete any/all confidentiality agreements required by the shelter to ensure client safety and to assure that the location of the shelter remain confidential and not shared with ANY-ONE including friends and family, _____ (home visitation program) will take all precautions to ensure victim/survivor safety and assign staff to work with shelter clients that have training on domestic violence.
- 4) _____ (domestic violence agency) and _____ (home visitation program) agree to work to the amount feasible to ensure that each family has a consistent staff member assigned to assist them and to minimize the transfer of cases involving domestic violence.
- 5) _____ (domestic violence program) agrees to provide every victim/survivor seeking services with safety planning (including safety planning for children) and information on how to meet their basic human needs (such as food, housing and clothing), including offering to connect her to (home visitation program) as part of a supportive case management plan.

We, the undersigned, approve and agree to the terms and conditions as outlined in this Memorandum of Understanding.

Executive Director
Domestic Violence Program

Executive Director
Home Visitation Program

Date

Date



EXAMPLE OF THE LOVING PARENTS, LOVING KIDS SAFETY CARDS (ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.FuturesWithoutViolence.org/health.

Hablemos acerca del embarazo

- ¿Mi pareja apoya mis decisiones en cuanto a si quiero o cuándo me gustaría tener más hijos?
- ¿Se niega mi pareja a usar condones cuando se lo pido?
- ¿Mi pareja me obliga a tener sexo cuando yo no tengo ganas?
- ¿Ha intentado mi pareja embarazarme (recientemente o en el pasado) sin que yo lo desee?

Los embarazos no planificados, especialmente aquellos que se dan muy cerca de su primer embarazo, pueden dificultar que usted cuide de los niños que ya tiene.

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Cómo tomar el control

Es posible que su pareja vea el embarazo como una manera de mantenerle en su vida y seguir cerca de usted a través de un hijo - incluso si eso no es lo que usted quiere.

Si su pareja le presiona para tener sexo, trata de interferir con sus anticonceptivos o se niega a usar condones:

1. Hable con su proveedor de servicios de salud acerca de métodos anticonceptivos que pueda usar sin que su pareja sepa (por ejemplo - DIU, anticonceptivos de emergencia (EC), Depo, Implanon).
2. Pregunte a su visitador domiciliario acerca de programas locales y nacionales que se dedican a ayudar a las mujeres que batallan con problemas de control o abuso en sus relaciones.

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**FUTURES
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Funded by the Administration on Children,
Youth and Families, U.S. Department of
Health and Human Services and the Office
on Women's Health, U.S. Department of
Health and Human Services.

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Si se siente frustrada o enojada
con sus hijos y sencillamente necesita
hablar...

Para recibir asistencia confidencial llame a:

Ayuda para niños
1-800-422-4453

**Si su pareja está haciéndole daño
usted no tiene la culpa. Para recibir
asistencia llame a:**

**Línea Directa Nacional para la Atención de la
Violencia Doméstica
1-800-799-7233
TTY 1-800-787-3224**

**Línea Directa para la Atención de Casos de
Violencia Sexual
1-800-656-4673**



**Padres Amorosos,
Hijos Amorosos:
Creando Futuros Sin Violencia**

Let's Talk Pregnancy

- Does my partner support my decisions about if or when I want to have more children?
- Does my partner refuse to use condoms when I ask?
- Does my partner make me have sex when I don't want to?
- Has my partner ever tried to get me pregnant (recently or in the past) when I didn't want to be?

Unplanned pregnancies, especially if they are closely timed after your first pregnancy--can make it difficult to care for the children you already have.

Taking Control

Your partner may see pregnancy as a way to keep you in his life and keep connected to you through a child—even if that isn't what you want.

If your partner pushes you to have sex, messes with your birth control or refuses to use condoms:

1. Talk with your health care provider about birth control that you can control and that your partner doesn't have to know about (examples--IUD, Emergency Contraception (EC), Depo, Implanon).
2. Ask your home visitor about local and national programs to help women struggling in their relationships with control or abuse.

If you are feeling frustrated or angry
with your child and just need to talk...

For confidential help call:

Child Help
1-800-422-4453

**If you are being hurt by a partner it
is not your fault. For help, call:**

**National Domestic Violence Hotline
1-800 799-7233
TTY 1-800 787-3224**

**Sexual Assault Hotline
1-800 656-4673**

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**Loving Parents,
Loving Kids:
Creating Futures without Violence**



Creating Safe Homes

Am I in a healthy relationship?

- ✓ Is my partner kind to me and respectful of my choices?
 - ✓ Does my partner help when the baby won't stop crying?
 - ✓ Am I ever afraid of my partner (of being hurt, shamed)?
 - ✓ Am I ever afraid to leave my baby alone with my partner or boyfriend?
- Your partner should help support you being a good parent and help create a safe home for you and your children.

What About Your Childhood?

- ✓ Did you (or your partner) see your mom hurt (beat up) by your dad or her boyfriend?
 - ✓ Did you (or your partner) experience unwanted sexual touching by someone in your family?
 - ✓ Did you (or your partner) have injuries or live in fear of being hurt by someone in your family?
- If you answered YES to ANY of these questions you are not alone. Talking about these experiences with your home visitor or a friend can help.

Parenting is Hard Work

Parenting after being hurt by someone you know and love can make the work even harder. Many parents who were abused can be triggered easily, quick to anger, have less patience and have more anxiety. These are learned responses to what previously happened to you, but there are strategies to make it better:

- If you feel frustrated, gently place the baby in the crib while you catch your breath in the next room.
- If you feel unsure about your partner's ability to handle their frustration with the baby, don't leave the baby alone with them.
- Find a safe person that you can call to take a break if you are frustrated with your baby and call your home visitor for support.

How Are My Children Affected?

Children who live in homes where their mother has been hurt or experience harsh punishment are more likely to have learning and behavior problems. Getting help for you is a great first step for them.

Here are ways to help your children:

1. Let them know that what has happened is not their fault.
2. Ask your home visitor or pediatrician about programs to help children exposed to violence.
3. Stay connected to your children and listen to them. Your relationship with them is the most important thing to keep them on track.

Creando hogares seguros

¿La relación que tengo es SALUDABLE?

- ✓ ¿Mi pareja es amable conmigo y respeta mis decisiones?
 - ✓ ¿Mi pareja me ayuda cuando el bebé no para de llorar?
 - ✓ ¿Le he tenido miedo a mi pareja (de que me lastime, o avergüence)?
 - ✓ ¿He tenido miedo de dejar al bebé solo con mi pareja o novio?
- Su pareja debe apoyarle con el cuidado de los niños, y ayudar a crear un ambiente seguro para usted y sus hijos.

¿Qué paso durante su infancia?

- ✓ ¿Usted (o su pareja) vieron a su madre ser lastimada (golpeada)?
 - ✓ ¿Usted (o su pareja) experimentaron manoseos de tipo sexual por parte de algún miembro de la familia?
 - ✓ ¿Usted (o su pareja) han sido lesionados o viven con el temor de que algún miembro de la familia les haga daño?
- Si contestó SI a CUALQUIERA de estas preguntas, sepa que hay ayuda disponible. Hablar con su visitador domiciliario o un amigo acerca de estas experiencias puede ayudarle.

Crear a los hijos es un trabajo duro

Crear a los hijos después de haber sido lastimada por alguien que conoce y ama puede complicar aún más esta tarea. Muchos padres que han sufrido abusos pueden perder el control con facilidad, enojarse rápidamente, tener menos paciencia y sufrir más ansiedad. Estas son respuestas aprendidas a lo que pasó en el pasado, sin embargo, hay estrategias que permiten mejorar la situación:

- Si se siente frustrada, ponga al bebé suavemente en la cuna mientras se calma en el cuarto de al lado.
- Si no se siente segura de su pareja para controlar su frustración con el bebé, debe evitar dejarlo solo con esa persona.
- Encuentre a una persona de confianza a la que pueda llamar para darse un descanso si se siente frustrada con su bebé, y llame a su visitador domiciliario para conseguir apoyo.

¿Mis niños están resultando afectados?

Los niños que viven en hogares en los que la madre ha sido lastimada o en los que se aplican castigos severos son más propensos a tener problemas de aprendizaje y de comportamiento. Conseguir ayuda para usted misma es un buen primer paso para ellos.

Estas son algunas maneras en que puede ayudar a sus hijos:

1. Déjeles saber que lo que ha pasado no es culpa de ellos.
2. Pregúntele a su visitador domiciliario o pediatra si hay programas para ayudar a niños expuestos a situaciones de violencia.
3. Manténgase conectada con sus hijos, y escúcheles. Su relación con ellos es el punto más importante para mantenerlos en buen camino.

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BIRTH CONTROL EDUCATION

Methods that clients can use without their partners' knowledge

All of these methods (except Emergency Contraception which can be purchased over the counter at a pharmacy by men or women 17 or older) must be prescribed by a doctor or nurse practitioner. Clients can call 1-800-230-PLAN to find a health care provider near them who can prescribe birth control. Talk to your client about safety planning around doctor's office reminder calls, and scheduling visits—if making appointments for birth control may put them at risk with a partner.

WHAT IS IT?	HOW DOES IT WORK?	HOW LONG IS IT EFFECTIVE?	HELPFUL HINTS	RISKS OF DETECTION
Implanon	A matchstick-sized tube of hormones (the same ones that are in birth control pills) are inserted in your inner arm.	3 years	Unlike previous implantable methods (Norplant), is generally invisible to the naked eye and scarring is rare.	Implanon might be detected if palpated. Periods may stop completely. This may be a less safe option if her partner closely monitors menstrual cycles.
Intrauterine Device (IUD) - Mirrena & ParaGuard	The small T-shaped device, which prevents pregnancy by changing the lining of your uterus so an egg cannot implant, is inserted into your uterus.	ParaGuard: 12 years Mirrena: 5 years	Mirrena has a small amount of hormone that is released that can lessen cramping around the time of your period and make the bleeding less heavy.	The IUD has a string that hangs out the cervical opening. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel them or pull it out of her.
Depo-Provera ("the birth control shot")	Depo-Provera is a shot that provides hormones—the same ones that are in birth control pills—that prevent a woman from ovulating.	3 months	Once administered, there is no way to stop the effects of the shot.	Periods may stop completely. This may be a less safe option if her partner closely monitors menstrual cycles.
Emergency Contraception (EC)	Either a single dose or series of hormones are given within 72-hours of unprotected sex to prevent pregnancy.	Single dose—must be taken after every instance of unprotected sex.	Clients can get emergency contraception to keep on hand before unprotected sex occurs. EC is NOT abortion—just like "regular" birth control pills, it prevents ovulation.	Clients can remove the pills from the packaging so that partners will not know what they are.
This is also referred to as the "Morning After Pill"				

SECONDARY TRAUMA

Common Reactions to Caring for Survivors of Trauma

Helplessness

- Depressive symptoms
- Feeling ineffective with patients [clients]
- Reacting negatively to patients [clients]
- Thinking of quitting clinical [contact with clients] work

Fear

- Recurrent thoughts of threatening situations
- Chronic suspicion of others
- Sleep disruptions
- Physical symptoms
- Inability to relax or enjoy pleasurable activities

Anger

- Reacting angrily to patients [clients] /staff, colleagues
- Feelings of guilt
- Decreased self-esteem

Detachment

- Avoiding patients
- Avoiding emotional topics during patient encounters
- Ignoring clues from patients [clients] about trauma
- Failing to fulfill social or professional roles
- Chronic lateness

Boundary Violation and Transference

- Taking excessive responsibility for the patient [client]
- Seeing patient [client] after hours
- Doing something out of usual practice patterns
- Sharing own problems with patient [client]
- Patient [client] trying to care for service provider

Use of Alcohol and Drugs

- Increased use of alcohol
- Initiation or use of drugs
- Misuse of prescription medication

Source: *Intimate Partner Violence*, 2009 edited by Connie Mitchell and Deidre Anglin, Oxford Press



POST-TRAINING SURVEY FOR HOME VISITORS

Thank you for providing feedback to us. The following refers to your home visitation clients, meaning the **adult caregivers/parents** caring for an infant/child.

The training today increased my understanding of:

- 1) How to discuss confidentiality with my home visitation clients before assessing for domestic violence (DV) or coercion
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 2) What local & national resources are available to assist my clients around domestic violence (DV) and childhood violence (including witnessing domestic violence, childhood abuse)
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 3) How to assess for domestic violence (DV) among my clients
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 4) How to assess for reproductive coercion among my clients
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 5) How to assess for domestic violence (DV) and childhood violence when clients are depressed or using substances
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 6) How to discuss birth control that is less vulnerable to partner interference
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 7) How to discuss safety planning with a client who discloses an abusive relationship
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree
- 8) How to discuss a client's experience with violence in their childhood and the possible effect on their parenting
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

Following the training today, I am more likely to:

- 9) Discuss the limits of confidentiality with my clients before asking about coercion or violence
A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree



Post-Training Survey for Home Visitors

10) Assess for domestic violence (DV) with all my clients

- A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

11) Assess for childhood experiences of violence (CEV) with all my clients

- A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

12) Assess for DV and CEV with any client who has a mental health or substance abuse issue

- A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

13) Provide information about DV/CEV to all my home visitation clients

- A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

Please circle at least one action item that you intend to do differently following the training today:

- A) Make safety cards related to DV/CEV and healthy parenting available to all home visitation clients
- B) Offer an in-service training for all home visitation staff on DV/CEV
- C) Set up a home visitation protocol for assessing for DV/CEV with home visits
- D) Other (please be as specific as you can): _____

What support do you need to incorporate discussion of domestic violence (DV) and childhood exposure to violence (CEV) in all your home visitation encounters? _____

Additional Comments: _____

Thank you for your time!



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Module 11: Mandated Reporting for Child Abuse: Challenges and Considerations

(No references for this module)



Module 12: Closing and Post-training Survey

(No references for this module)



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