# Transcription

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Megan: Hello, everyone, and welcome to the training on Domestic Violence and Reproductive Coercion for Home Visiting Providers webinar. I'm Megan Hiltner with the Healthy Start EPIC Center. I'll be moderating our webinar today. We have approximately 60 minutes set aside for this Ask the Expert webinar. It's being recorded, and the recording, along with the transcript and slides, will be posted to the EPIC Center website following this webinar.

The topic of domestic violence and reproductive coercion is such a broad topic. And because we only have limited time during this Ask the Expert webinar, we're going to focus on what home visiting programs can do in this practice. However, we recognize that Healthy Start grantees do much more than just home visiting programs.

I will be introducing your wonderful speaker here in a moment, but I have a couple of housekeeping announcements that I wanted to make. We really want your participation during the webinar, so if at any point you have questions or comments, please chat them in at the bottom left corner of your screen. We'll be taking questions via the chat box and we will be breaking at the end of Dr. Sharps' presentation to answer your questions. If we don't get to all those questions, we'll be including them in a Frequently Asked Questions document that will be posted on the EPIC Center website with the other webinar materials.

The other point I wanted to make is that you'll be asked to complete an evaluation survey at the end of the webinar. And we really do appreciate your feedback, so take a moment and complete it and give us your thoughts.

So now let me introduce your dynamic speaker for today. Dr. Phyllis Sharps is Professor and Associate Dean for the Community and Global Programs at Johns Hopkins University School of Nursing. In addition to being the Director for the Center of Global Initiative, she also directs the School of Nursing’s community-based centers. Dr. Sharps has published numerous articles on improving the reproductive health, reducing violence among African-American

women. Her practice and research examines the consequences of intimate partner violence against pregnant and parenting women, specifically the effects of intimate partner violence on the physical and mental health of pregnant women, infant, and very young children.

She's been the principal investigator for two NIH-funded grants, Domestic Violence Enhanced Home Visitation (DOVE), testing a public health nurse home visiting intervention to reduce effects of intimate partner violence amongst pregnant children and their newborns. She's also a fellow of the American Academy of Nursing and a member of the International Nurse Researcher Hall of Fame, Sigma Theta Tau International Nursing Honor Society. So with that, I'm going to turn it over to Dr. Sharps to continue with her presentation for today. Dr. Sharps?

Dr. Sharps: Thank you. Good afternoon. I'm very pleased to do this presentation for Healthy Start grantees. And as Megan said, the presentation is going to focus on the role of home visitors in addressing domestic violence and sexual violence. It really is important for home visitors to have an understanding of this and to know how it impacts practice.

We know that domestic violence and sexual violence has negative impacts on maternal health, pregnancy outcomes, child development, parenting skills, family safety, and social support. All of those things are important outcomes for a Healthy Start program. And we also know that if the domestic violence is not addressed adequately, program outcomes will never be as robust as if you are addressing those.

So we're going to start with an overview of what we're speaking of when we talk about sexual violence and domestic violence. And the objectives for this session are to look at the frequency and the prevalence of domestic violence, to define both domestic violence and sexual violence, to talk a little bit about why women stay in these relationships, and how you, as a home visitor, can be supportive and help women in violent intimate relationships.

About 25% of all women and 20% of teen girls every year experience reporting physical or sexual violence, and we call that lifetime exposure to violence. There are many definitions for violence, and they tend to be defined by who is actually defining them. So certainly legal definitions that perhaps police and other individuals might use are focused a lot on the physical and sexual assaults because those are legally defined and certain levels of evidence must be present.

But for us, we do public health work and nursing care and healthcare work. Our definitions are a little bit broader, and it includes any controlling behaviors such as emotional abuse, social isolation, stalking, intimidation, threats, and reproductive coercion. And we're going to talk a little bit about reproductive coercion because it definitely impacts reproductive health and some of the outcomes that you're striving to achieve in your home visit programs. So it includes public health. It includes all of those definitions as well as the physical and sexual assault.

It's important to also understand that violence against women and girls and children is really about power and control. It's not so much about anger, but rather the things that the perpetrator or the abuser does to keep the victim — in this case, often the woman — under his control. And much research shows that very often when abusers are doing these things, they're not angry at all. And there are a number of tactics that the wheel talks about in terms of isolation, stalking. These are ways that the perpetrator of the violence is able to create fear and control over the victim.

When we talk about sexual violence, it is very much in some ways similar as when we talk about physical violence. It's a type of activity or individuals engaging in sexual activity when one party, usually the woman, is not consenting to do that, and either by the use of threats or force or other kind of ways, intimidating women from themselves in a sexual situation that they really did not give consent to. So again, when you think about power and control, it is

an individual having power over the victim and forcing them to do something that they really don't want to do.

So again, it's forcing her to do sexual acts that she doesn't want to do. It is pursuing sexual activity when she's not fully conscious. So if she's drinking alcohol, if she's been injured, if there's drug use and the person is not really able to give consent… as well as with minor children. The law suggests that minor children are not fully capable of giving consent. And so that is what we're talking about in sexual assault and sexual abuse. It may not necessarily be the full act of intercourse, but it's also physically hurting sexual parts and creating fear. It also is forcing an individual to have unprotected sex, so again, increasing her risk for unintended pregnancy as well as sexually-transmitted diseases.

So it's important to think about how all these things are connected: sexual violence and domestic violence, sabotaging a woman's effort to control her fertility or to use birth control, pregnancy, pressure to be pregnant, or enter into sexual activities that would lead to pregnancy or unintended pregnancies when a woman really doesn't want to be pregnant. Those are some of the trajectories that can happen to a woman in intimate violent relationships.

So when we talk about reproductive coercion, it involves behaviors that a partner uses, again, to remain in control. So think about the power and control wheel, and that in this case, it's related to her reproductive health. So, again, attempts to impregnate a partner when she doesn't want to be and she's clearly made that statement. Controlling the outcomes of pregnancy… so perhaps denying abortion if it's a legal abortion early on, hitting or hurting an individual so that there is a loss of pregnancy, preventing women going in for pregnancy care so that there may be a poor outcome to the pregnancy. As I've said before, coercing a partner to have unprotected sex. Or even if a woman is attempting to use contraception, interfering with the use of contraception.

So birth control sabotage then is either destroying contraceptives, making condoms unusable by damaging them, preventing her from either using... let's say she's using birth control pills or other kind of devices — gels, creams — preventing her from using that, and/or threatening physical harm if she does attempt to use the contraceptive method.

So it's important to also think if you are in a home visit and you're going to be assessing or talking about these things, understanding and helping the individual be aware of the limits of your confidentiality and what's going to happen to the information that she gives you during a session, during a home visit. And so it is important for you to be aware of your state laws around confidentiality.

So these are types of questions you might ask if you're going to do an assessment for reproductive coercion: Does your partner make you have sex when you don't want to? Has your partner ever tried to get you pregnant when you didn't want to? Does your partner support your decisions about having children or using contraceptive methods? Is it a shared decision-making activity?

Of course, it's important after you talk with the mother about these kinds of things to express your concerns, and also after if she might need some additional assistance or if there are other people… one of the things that I think that's important in doing the work of screening for domestic violence and sexual violence and reproductive coercion is to know the resources in your community. You yourself don't have to be the expert, but if there's a shelter, if there is a social worker, if there is a domestic violence advocate that is readily available in your community, it would be important to get to know those people so that you're able to refer and connect mothers who might need additional help with some of the issues she may be facing.

So it's always important when you're talking to any woman about domestic violence or sexual violence to validate her experience, to give an empathetic

message, because women don't deserve to be hurt in this way. You could certainly have a safety card available with the National Hotline for Domestic Violence or perhaps information local to your community, and where she could go to learn about additional resources and other options. It's always important when doing the work around domestic violence and sexual domestic violence to make sure that the mom is safe. And if not, talk about what might be something that you and she could do together to maintain her safety or follow up after your discussion.

So always when we do the kind of work around domestic violence, people want to know why the men do use violence in intimate relationships. And I'm not sure that anybody really knows the definitive answer, but we do know it is about controlling and having power over an individual. And even in child abuse cases, it is the same thing. It perhaps works a little different because the parent usually is older and can maintain control over a child a little differently. But in intimate partner relationships, people generally enter into these relationships as two consenting adults. And in an intimate relationship where there is violence, the perpetrator maintains more control over the relationship.

Sometimes we have rules and values in our culture that suggest that men might have a different role with women and that women are seen as individuals to be controlled. And sometimes men and boys learn those things as they're growing up. We do live in a very violent society, not only in our communities, but a lot of the media that individuals are exposed to when they're growing up reinforces some of the behavior. Unfortunately, in some jurisdictions, in some states, men are able to get away with things. The laws are not as stringent or they're not applied. But more importantly, people learn to be violent. In general, children are not born violent, but along the way, they learn to be violent. So it's important to know that it is a pattern of behavior. People learn how to do the behavior, and the behavior is reinforced and it continues.

So there are a lot of reasons why women stay in domestic violence relationships. But over the years, as I have worked with women, I know that it is a process. And many women will attempt to leave many times — as many as

six or seven times — before they eventually leave a relationship. And I ask you to think about if any of you have tried to change a behavior — maybe it's smoking, maybe it's dieting — very few people do it on the first attempt, and it takes several attempts. And so it is with women. But more important to ask about why they don't leave is why women stay. And sometimes women stay because of fear and the threats of violence escalating, as well as the fear that the perpetrator is going to hurt the children in the home.

Even if they do leave, often there's no place to go. The shelters are often full. If you happen to live in a jurisdiction that has a shelter, often women are cut off or disenfranchised from their families and the communities. So there's a lack of support there. And if you're not working or have the ability to get a job, there is the financial reason for staying as well as concern about just the stigma of leaving either from your community, from your faith group. So there are many reasons why women stay in relationships.

So again, I think it's important for you to understand as a home visitor that you can make a difference. You don't have to be a domestic violence expert, but I think you've all been in situations when you know that there are families experiencing domestic violence and/or child abuse, and that, as a home visitor, you have a very unique relationship with women. And you're there frequently and you have the opportunity to build a relationship to provide education. And my own research has shown that women, if you provide the opportunities, often need to tell their stories. And they won't drop out of programs necessarily because you ask them about them.

It's important… I hope by now that you can see that the connection between the domestic violence… often women use certain substances — alcohol, cigarettes — to kind of cope with the violence and depression. So these things rarely happen in isolation, and you may find women suffering with all of these situations. It's particularly difficult when the partner is a controlling or threatening individual. And women in those kinds of situations, even if the violence is not so bad, will have persistent symptoms of depression and maternal postpartum depression, which I know Healthy Start programs are

screening mothers for depression. So one of the things to kind of think about is when you're screening for depression and you find that a mom is depressed, consider whether or not there may be domestic violence going on.

So psychological abuse by a partner in much of the data… in the PRAMS data, for instance, the greatest predictor of maternal depression was a history of partner abuse. So again, the things often occur together: depressive symptoms, substance use, chronic mental health. And often, there is a pattern of victimization, sometimes starting from child abuse and then progressing later as teenagers as dating violence and then intimate partner violence.

So again, many of the families that we see in our Healthy Star programs, families are struggling with issues around mental health, issues around depression, and often use of alcohol, cigarettes and other drugs to cope with a very painful situation. And don't forget that there can also be mis-abuse of prescriptions and over-the-counter drugs, not just illicit drugs.

So one of the things to be thinking about is what we call integrated screening, so that you're screening about all of these conditions. And it doesn't need to take a lot of time. Three questions for domestic violence screening has been very important. Alcohol use by one question, and a couple of questions for depression in terms of feeling blue, feeling hopeless, feeling down. Again, when I'm screening for domestic violence, I don't ask women if they're victims of domestic violence because people, in general, don't like labels. But you really just want to ask specifically about the behavior: kicking, hitting, and that kind of thing. People can respond to behaviors.

And all the time when I do these presentations, people always want to know about the effect of domestic violence on children, and so I've added this to presentations. And it's important to point out that I think many people probably understand the impact on toddlers, pre-school children, but we now know that even the smallest infant is impacted when there’s domestic violence between their caregivers. Kinds of things that you may see in the youngest infants are

failure to thrive, and then as children get older, bedwetting, speech disorders, GI symptoms, vomiting and diarrhea, asthma, allergy, GI problems, as I said, and headaches. In addition to the work I do in shelters, I also work at school health, and a number of kids come to the school health clinics with headaches, very vague symptoms. And again, I'm not saying that domestic violence causes asthma, but it's likely to exacerbate the symptoms when the children are stressed by what's going on in their homes.

For older children, we've been able to identify the risks for posttraumatic stress disorders, for depression, for anxiety, and for aggressiveness. And often, in the shelter that I work at here in Baltimore, mothers come with their children. And it is amazing to me how even the youngest children, and especially little boys, are very aggressive. And so again, remember that violence is a learned behavior, so that child is imitating something that they have seen in their homes.

So again, later on, as children enter into the school system, often children that have been exposed to domestic violence and ongoing violence in their home are more likely to be seen by the school nurse, may have difficulty with speech and language development. Frequently, they are absent from school and they tend to do poor in school, and because of their aggressive behavior, often find themselves in bullying situations or other situations where they're suspended from school.

In terms of just knowing that generally the domestic violence and child abuse or child neglect may occur together… and it's important for, I think, home visitors to convey to mothers that probably one of the best things that they can do for their kid is just being there, and that the presence of a healthy adult and a caring adult is the one important thing that contributes to resiliency of the child.

I'd like to talk just a little bit and close out the presentation with a promising intervention that has been implemented in some Healthy Start programs and other home visit programs, and that is the intervention that I've developed

called the DOVE, which is an acronym for Domestic Violence Enhanced Home Visitation. It is a brochure-based intervention, and the brochure is a modified brochure that appears in the March of Dimes module for abuse during pregnancy. We actually have tested it scientifically through funding from NIH and found that women who participated in the DOVE intervention did report less violence. We deliver it as women enter into the home visit programs here in our area early in pregnancy, and we also deliver sessions after they deliver the baby. So a total of six sessions. We like three ideally before the baby is born, and then three in early postpartum period.

One of the things that is often a challenge for implementing DOVE or any program is screening in the home and how you create privacy. Because you want to only be asking the woman and you only want her to be listening and not small children, not partners, not other people around. So you may suggest to her that there a few private things you want to talk with her about. Is there a place to go? Sometimes when I'm not able to do that, I actually hand the screening to the woman and let her fill it out so she doesn't have to talk out loud. But it's important that you do find a place that you can screen in private, where the kids are not there and other family members or neighbors are not around to listen.

So early on in your home visiting protocol, you want to do your first assessment. Often, it's not the first visit because we understand that there's a lot that needs to be done on those first intake visits. But early on, and then in another month or so because the course of relationships change over time, and then again during the postpartum period.

Also be aware that you may see some indicators just in the smallest infant or postpartally after the baby is born, and it may trigger you to do an assessment. We use the abuse assessment screen, and it's a very quick screen. And you'll notice that it doesn't ask her if she's a victim of domestic violence, but rather, it asks about specific behaviors. So have you been hit, kicked, or slapped, or pushed? Or have you been forced to have sex when you didn't want to? Are you afraid of your partner?

When we implement a DOVE intervention, as I said, it's a brochure, and we start talking about the cycle of abuse. And what's nice about this is that women get kind of to tell their story about how it happens, and many women need to do that. We go on to talk to women about why we are concerned about abuse during pregnancy. We talk about the potential pregnancy outcomes, the impact on her own health and the impact on her children, again, born, infant's health.

We also talk to women about options. And the reality is we know that most women are not going to leave an abusive relationship during pregnancy, but we can talk to women about staying safe and creating a safety plan. A safety plan is just a way for her to think about how she can keep herself and her children safe. And again, you don't have to be the expert on this, but I think that if you are connected with your domestic violence advocates, or if there's a shelter or social workers in your jurisdiction, they can be very helpful and can help women think through this and what might work for them.

So again, a safety plan is putting together several strategies, access to resources and things that can help moms stay safe during the pregnancy. What is nice about a safety plan is we start from a strength-based approach about mothers using things that have worked in the past, pulling on perhaps her social network and her friends, and building on her own knowledge of her situation and what might work for her.

I'd like to say a little bit about you as home visitors. And we would all acknowledge that this is hard work we do, but important work. And so you yourself maybe find yourself being traumatized by working with women. And so we call that secondary traumatic stress. Some people call it burnout. Some people say it's compassion fatigue. But it's the kind of energy and caring that you put in to impact the lives of the women you're working with, but also takes a toll on yourself. And so it's important that you recognize that that may be happening to you, that sometimes home visitors have their own experience of domestic violence or partner violence, and understanding how working with

women may also re-traumatize you, and that there's a place in your work that you have an opportunity for support and to talk through these things.

The other important thing is to also make sure that you are taking care of yourself as a home visitor. That is important. And I know I'm preaching to the choir, but that you take care of your own self, getting adequate sleep, adequate rest, and also a time to breathe. It's also important as a home visitor that you make sure that it is safe for you when you're going out, and particularly if it's a family where you know that there may be family violence. And so your agency should have a protocol for safety for you, either having a cellphone or some way to connect, that people know the route you're going to, what time you were expected to be at the family. Look at the place when you're going in and have a safe place to park. Make sure that before you enter the house, the mom is there. Look around.

And there have been a couple of times when I've had to make a fast escape, but just to kind of know where you are. And often, if the abuser is there, we come up with a safe code. The mother and I can know if this is a safe time for her, for you to do the visit. And I also encourage my home visitors to take materials that you could include if the male partner is there in the visit, so fathering kinds of things. And you can switch the conversation so that you can kind of diffuse his over concern and potential to become aggravated.

I highly recommend if you're not familiar with the Futures Without Violence website, there are lots and lots of information there and materials that you can use. There's handouts to augment your domestic violence programs. There's screening tools that can be used and modified for work with your agency, my contact numbers, if people are interested. And I think we will stop now for questions and comments.

Megan: Thank you so much, Dr. Sharps, for that very informative presentation and overview. One of the resources that you had given earlier when you were doing your overall presentation was the National Domestic Violence Hotline.

And so I thought I'd chat that into everybody so they have that information available. It was a website that you had cited with a phone number. And I know you just shared two other resources, the EndAbuse.org resources, so I can chat those websites into the chat box as well. But I'm wondering if folks are looking in their jurisdictions for more local resources, can you give any suggestions as to where they can look for more local resources or any maybe more overarching resources that has a repository for more local resources?

Dr. Sharps: So most states have a domestic violence coalition, so I would start there, and they can help you with the more local resources. Many states and city areas or county areas also have a homeless shelter or domestic violence shelter. And that, I have found, getting to know the advocates and the case managers in the shelter, have been invaluable for the work. So not every woman will want to or will go into a shelter, but many of the shelters do provide outreach materials. Another website is also the Nursing Network on Violence Against Women International. There are a number of free resources and screening tools that can be downloaded, and then agencies can develop those materials specific to your local area.

Megan: Great. I'll chat that website. I'll get the formal link for that website and I will put that into the chat box. And while I do that though, a question has come in. This is regarding rural areas. So this person asks, "What options do we have in rural areas with limited resources to assist women and children of domestic violence?"

Dr. Sharps: So it's interesting that you asked that question because the DOVE project, we did implement in both rural areas and urban settings. And certainly what we learned from women in the rural areas is that often they're reluctant to use shelters in their own area because the area‘s so small. People would know who they are. But, again, I think reaching out to the Futures Without Violence site and also End Abuse… there's lots of materials there. I think reaching out to whatever your hospital or women's health services, often there are social workers there and advocates that can get women connected to resources or important places. And even the National Hotline has GPS, so that wherever you

call in from, they know where you are, and so you could ask for specific resources. But I would begin, again, with the state. The state usually has a domestic violence coalition even in rural areas, and they can be very helpful.

Megan: Great. Okay, another question has come in. "As you stated, that much of the motivation for intimate partner violence is power and control. Is it known and/or has it been researched if the perpetrator is consciously aware of his desire for power or control, or more of a subconscious behavior pattern for the perpetrator?"

Dr. Sharps: It's probably a little bit of both. It is often a case of extreme possessiveness, extreme jealousy, and so whatever it takes to maintain that control… often, it's about physical, but it can be other things like stalking or preventing you from seeing other people, or wanting to know… and if you talk with women, and particularly teenagers, they will often talk about things like mistaking those things for signs of love that, "He wants to know where I am all the time. I went to visit my friend and he was there," kind of thing. So it's such a fascination with the relationship, and I think that most of research show that they are pretty aware of the things that they are doing. They often have no remorse for the things that they are doing and tend to blame the woman or the victim for causing him to do those kinds of things.

Megan: So another person chatted in that they're a fatherhood engagement specialist, and he's wondering what are the signs that he can look for in men that abuse or men being abused.

Dr. Sharps: Well, for men who are abused, if you're thinking about childhood and teenage abuse, they often have mental health challenges, often have difficulty with intimate relationships. I think if you're looking for a man who may actually be perpetrating, I think you ought to ask the question, just like we screen women, and ask, "Does your partner hit you, push you, strangle you?" that kind of thing. I would reverse the questions. And we should be screening men also. "In your relationship with your partner, have you ever pushed,

kicked, hit?" or that kind of thing. "Have you ever forced your partner to have sex when they didn't want to have?" is one way.

Often if a man, for instance, comes to a pregnancy appointment with the partner, he wants to be there all the time. Most men are happy to wait in the waiting room, but it's kind of the over-protectiveness. It's kind of if you're doing the interview and the woman constantly is looking at the man before she answers the question, that usually is a sign that there's at least controlling behavior. If a man has a history of other kind of violence, you definitely want to ask if that violence carries over to his family. If there is an issue with alcohol use or drugs, again, I think you would want to ask that individual. So we advocate that we should be screening men and women because there are two people involved in these relationships.

Megan: All right. So there are no questions in the hopper at the moment, but why don't I go ahead and give a few reminders about some upcoming webinars and give folks a chance to ask any other questions they may have about your presentation? And then we can revisit that as soon as I go through a few upcoming webinars.

So folks, we have three upcoming webinars in June. The first one is on June 4 from 3:00 to 4:00, that's an Ask the Expert webinar in Quality Improvement, basically a Quality Improvement 101 for Healthy Start grantees. On June 11, this is Part Two of the Hear From Your Peer webinar that took place last week, and this presentation is Fatherhood/Male Inclusion Engagement Strategies and Marketing for Males. That's from 3:00 to 4:30. Then on June 25, from 3:00 to 4:00 p.m. Eastern Time, there is a webinar in Behavioral Health Screening, Caring for Pregnant and Postpartum Women Struggling with Addiction. You can register for all of these on the Healthy Start EPIC website that's listed here. And all of the webinar info is included on the website that you can go access if you're able to be on the webinar, and you can check it out when you have time. And again, these aren't required. If you know one of your team members that this content would be relevant for, feel free to forward it along to them.

So at this point, still, we don't have any other question. Oh, wait. We have a late-breaking question that just came in, Dr. Sharps. "In speaking about intimate partner violence and domestic violence, the 'usual definition' is with a significant partner. Can it still be considered intimate partner violence if it is another living in the household, for example, a sibling or a cousin, who is the perpetrator, or a child abusing a parent? Are there implications/strategies to assist with this the same way you've addressed it with a romantic partner?"

Dr. Sharps: Well, so that is generally why I don't use the term “domestic violence” because I specifically work with intimate partner violence. And so those male/female intimate partners, they can be same genders, so male to male, female to female. To me, domestic violence is a broader term, and it does cover what you're talking about, siblings and cousins perhaps entering into violent relationships, parents, children against parents, and that kind of thing. And yet there are strategies for that, so if it's sibling and cousins, one might want to make sure that it's not... the age differential makes a difference. If the child is being abusive towards a parent, and I'm assuming you're talking about a young child, that probably is an area that your Child Protective Services and Family Preservation wants to be involved because there may be some other issues with the child's mental ability or that kind of thing that's going on.

Certainly, there can be incest, with incest where there's inappropriate sexual activity between parents and children. And again, that often will call for separation. So the other thing I would say is that if you are working with a family and there's an issue around children and violence, that you really want to get to know the Child Protective Services people. Not so much that you're going to always be calling and reporting, but there are a lot of services for families that you could call people to come in before a family gets to the point where they have to be separated.

The other thing, too, in terms of talking about confidence, if you are a healthcare provider or helping profession, be sure you understand your state

laws. So, for me, as a nurse, I'm a mandated reporter. And so I let families know right up front that if there are child abuse and that kind of things, I'm obligated to make a report. I'm not going to go back and make the report without telling you. I'm going to call and talk to you. Sometimes there's already an open case, and so maybe it's not necessary for me to call. But if you want to build rapport with family members, you don't ever want to be in a situation where they find out after the fact that you called them in because of information they shared with you.

So I've always made it a point to know who the people are in my community that work in Child Protective Services, what resources I could mobilize and call upon. And, frankly, Child Protective Services in most jurisdictions is so overwhelmed, and if you're in the home helping, they are going to not necessarily react as quickly because they know you're there and they're helping. And they're often willing to share resources with you. So that's a good thing that you could do when you're working with these kind of families.

Megan: Great. So this question, Dr. Sharps, is really kind of a general question. And the person asking suggested... well, I'll just ask the question and then you can respond. "In your experience, what is the most effective way to help an abused partner leave the home? Is it to make a change? What about the effects on children? Are there other options for the mom? Is it to offer resources? Or are there other approaches to help the partner leave a situation?"

Dr. Sharps: Well, no matter how bad a particular situation is, unless she's in imminent danger and I have to call, I never start out with an approach of trying to convince people to leave. Women will know when it's the right time for them to leave. But what I do offer is education, effects on the children, effects on her, what resources are available. Because if you're going to advocate for somebody to leave, then you'd better be sure you have some place for them to go. And sometimes the shelters are full. Sometimes they are not able to go to family members. Even if they do go to family members and that family member is in the same community, they're very worried that the partner is going to then stalk the family or hurt her mother or her father, that kind of thing.

So it's not as easy as it would be, and it often is not our role to do that. In general, as I said, it's a process, and women will usually come to that on their own. And most often, they come to it when they realize that this partner is capable of hurting their children. Because women love their children. And they're willing to maybe sacrifice themselves, but when they understand that this might hurt my child, they often are able to think about that. So I think just making sure resources are available, keeping them connected with community resources, providing them with information, and helping them, empowering them to make the decisions and the choices that are right for them are the best role we can play as home visitors.

Megan: That was a great response to a really good question. And moving on in this same subject, can you please talk a little bit more about the heightened danger when that woman does decide to leave, that sometimes the partner does not always display signs of danger?

Dr. Sharps: Yes. So again, just from my own work… and we've published some studies that show that often women who were hurt severely or murdered by a partner was when she was in the process of leaving. And so if a woman is deciding to leave, it really is important, I think, to have the shelter or social worker or other advocates involved. I often suggest to women… usually the scenario is, "I'm going back home to pick up things for myself or the kids," and the partner says, "Oh, absolutely. I won't be there," or "You can come." And there she is in the home with this very dangerous man and… you know.

We have amazing brains. We would all like to remember the best things. And so while on one hand you may really think this person is going to kill you, you don't want to believe this about somebody that you love and that you've had children with.

So if women find themselves that they need to go back to the home or other places where he might be, I suggest — and that's where advocates can be of help — that they take someone, a brother, a father, an uncle, maybe they need to call the police and have an escort or something. And there may be resources in the community so that she can go back safely and get those things that she needs. It probably is important that she's in touch with legal resources, and she's going to have a restraining order or that kind of thing. If she's working, she may want to let her employer know that "I'm in the process of leaving my partner. He may show up to work or come to my workplace. Don't just let him in the door," that kind of thing. And I think that's where an advocate can also help her think through what are the possible scenarios.

Megan: Great. So one final question, Dr. Sharps… and I think you touched on this earlier, but I want to give a reminder to folks. Where can they go to get more information about the DOVE program?

Dr. Sharps: If they contact me, it was the psharps one. I think when you post the slides, it's the last slide.

Megan: There. Yeah.

Dr. Sharps: If you just contact me… and I have gone to several states to do trainings in different jurisdictions, so it's something we can consider. This presentation was done by my colleague, Dr. Bullock at the University of Virginia, and myself, and in consultation with Futures Without Violence. So that's why you see so many logos.

Megan: Great. Very collaborative, that's great. All right. Well, thank you so much, Dr. Sharps, for the great information. We don't have any more questions pending, but I just, again, wanted to thank you for your time. And for those participating, thank you so much for your participation and your great

questions. This concludes our webinar for today. Thanks so much for your participation to all listening and for Dr. Sharps.

Dr. Sharps: Thank you.