Presentation Skills

BACKGROUND INFORMATION

PRE-SESSION

- Pre- Session Desired Outcome – provide information, change behavior, influence attitude, etc. Most people want to leave a training session being able to clearly identify the new skill or information they learned.
- Format – lecture, discussion, activities, question and answer, etc.

APPROACH TO TRAINING

	Adult Learning Approach…	**Rather than...**
Focus	Participant-directed (self-directed) learning	Teacher-directed learning
Belief about learner	Self-directed, thinking, motivated	Dependent personality
Role of learner's experiences	A valuable resource, contributes to learning	To be built on more than used
Readiness to learn	Develops from real-life tasks and problems	Dictated by curriculum
Orientation to learning	Task, life or problem centered, improving individual skills and performance	Subject-centered
Motivation	Internal incentives, curiosity, see personal benefit	External rewards and punishments
Teaching methods	Interactive, utilizing all learning styles	Lecture, one-dimensional
Purpose	Help learners succeed	Evaluate whether or not people can "make it"
Climate	Respectful, collaborative, supportive, informal	Authoritative, judgmental, formal

Adapted from Malcolm S. Knowles, Department of Adult and Community College Education, North Carolina State University, January 1997

4-STEP TRAINING METHOD

Prepare the learner by putting the learner at ease, arousing the learner's interest and finding out what the learner wants to gain.

Present the information by telling, showing, and explaining.

Practice the information by allowing the learner to describe process, demonstrate process and explain information. Re-instruct as needed.

Evaluate to find out if the learner has met objective. If not, determine what the trainer needs to do to ensure that the learner is comfortable with the new skills.

LEARNING STYLES

Dependent Learner
Occurs in introductory courses, new work situations.
Learner has little or no knowledge.

Teaching techniques:

- Provide goals and objectives
- Frequent demonstration and structured practice
- Easy steps
- Focus on survival skills
- Encourage questions

Collaborative Learner
Learner has some knowledge of the subject, information or idea.
Learner likes to share.

Teaching techniques:

- Provide schedule or agenda
- Decrease amount of time for demonstration
- Increase amount of time for practice

Independent Learner
Learner has a lot of knowledge or skill and wants to continue on their own.

Teaching techniques:

- Provide challenging activities
- Provide problems for them to solve
- Provide lots of facts and data
- Don't "waste" their time by repeating information

PRESENTING INFORMATION

POSTURE

- Stand straight but not stiff.
- Point feet toward audience and distribute your weight evenly.
- Avoid shifting your weight back and forth.
- Keep shoulders oriented toward audience.

GESTURES

- Gesture naturally, as if in conversation with a friend.
- Keep gestures above the waist.
- Don't speak with a pen in your hand. The audience will focus on the pen and not on what you have to say.
- Avoid: putting hands in pockets, locking hands behind your back, crossing your arms, fig leaf position, and wringing hands nervously.

EYE CONTACT

- Look into the eyes of people in the audience. This establishes rapport.
- Focus on one person for 1-3 seconds, then smoothly move on to another person in a slightly different part of the room. Avoid darting your eyes around the room.
- If you are using visual aids and you need to look at them, don't speak unless you have eye contact with the audience. Don't talk to the screen or the flip chart.

VOICE

- Take a deep breath before you begin speaking to help moderate your voice and relax yourself.
- Speak with your audience, not at them.
- Listen with your eyes – be aware of audience's body language, posture and other non-verbal cues.
- Speak from your heart and experience, not from a script. You will sound more natural.

PRACTICE

- Practice in front of a mirror or video tape yourself.
- Don't try and memorize a speech word for word. Memorize your concepts and use an outline to trigger thoughts. Your are more able to speak with conviction and connect with the audience.

WARM-UP BEFORE SPEAKING

- Loosen up by smiling, yawning, using facial stretches, and doing shoulder rolls and shrugs.
- Visualize your audience responding positively to your presentation.
- Make small talk with members of the audience before your presentation and during breaks.

VISUAL AIDS

GENERAL

- Research shows people remember 10% of what they read, 20% of what they hear, 30 % of what they see and 50% of what they see and hear.
- Visual aids must support the content of the spoken message. Usually use for summarizing key points or words.
- Must be interesting to the participants.
- Must be easy to read from a distance.
- Don't just read from your visual aids.
- The amount of detail on your visual aids varies depending on the type of information presented and the written material provided. For example, information that is highly factual, process or numbers oriented material needs more detailed visual aids then other types of information.

FLIP CHART

- Inexpensive and portable. Good with small to medium size groups. Can use to post information you want to refer to later on.
- Write legibly with letters at least 2 inches high. Use the fat side of the pen.
- Have a heading at the top of each page.
- Approximately 10 lines per page maximum.
- May want to alternate colors on the page so people can easily distinguish between points.
- Types of flip charts:
  1. Prepared flip charts – information already written on a flip chart page Example: key points or key words
  2. Semi-prepared – some information already written on page, more is written during session. Example: topic headings are already prepared and you fill in the details during the session
  3. Blank - information is written on the page during the session. Example: lists that are generated during a brainstorming session.

OVERHEAD PROJECTOR

- More costly than flip charts. Good with medium to large size groups.
- Called many things: transparencies, overheads, slides, PowerPoint
- Prepared, semi-prepared and blank (see flip chart information)
- Use at least 18 point font size for prepared overheads but will probably need larger. Don't crowd the page. On PowerPoint try not to use anything smaller than 28 point font size.
- When working with transparencies, markers can erase with a wet paper towel, so they are useful if you want to revise something during a session.
- Write legibly.
- Make sure images appear straight to the audience by looking at the screen and checking the focus. For transparencies you can mark the edges of the projector with tape before the presentation. Make sure the projector and screen don't move during your presentation. Turn off the projector when you are not using it.
- LCD projectors allow us to show video clips, use audio and present outstanding visuals HOWEVER…too much of a good thing is too much. Use special effects judiciously so they don't become overwhelming or distracting.
- Make sure you have an extension cord and a surge protector especially if you are providing training in rural areas.
- Remember, your PowerPoint or other visuals are just part of the package. Slides can help you focus your talk but it is never a good idea to merely read the slides to training participants.
- Occasionally have some one in the group read the slides, use the slide as talking points but illustrate your points with a story or an activity.

TRAINING METHODS

LECTURE

Purpose:
Provide information to a group of people.

Advantages	*Disadvantages*
Efficiently provide information. Everyone receives the same information.	One-way communication.

LARGE GROUP DISCUSSION

Purpose:
Draw upon knowledge and ideas of group.

Advantages	*Disadvantages*
Provides interaction. May get more information than a lecture would provide.	Information provided can be off-topic or inaccurate. Takes time. Not everyone gets to or is comfortable sharing ideas.

SMALL GROUP DISCUSSION

Purpose:
Draw upon knowledge and ideas of the group.
May assign each group a specific issue/problem to discuss.

Advantages	*Disadvantages*
Gets everyone involved. Many ideas generated.	Takes time.

CASE STUDY/SCENARIO

Purpose:
Group applies information presented to a specific problem or situation.
Individual or small group activity.
May use as an introduction to generate discussion on subject.
Use instead of lecture to draw upon group's experiences and ideas.

Advantages	*Disadvantages*
Helps people see application of information presented. High level of interaction.	Case studies are not viewed as "real world." Takes time.

DEBATES

Purpose:

Thoroughly discuss all sides of an issue.
Help people understand others' perspective.
When people have strong opinions you can have them argue the opposite side.
Good to use when you are biased towards one side.

Advantages	*Disadvantages*
All sides of an issue are given air time. Can have lively participation. Not used often so has a novelty factor.	Takes time. Requires strong facilitation skills, especially if tempers flare.

ROLE PLAY

Purpose:

Practice skills that were taught.
Types: small group, demonstrations in front of entire group (fish bowl).

Advantages	*Disadvantages*
Practicing the skill is more difficult than responding to a case study/scenario so there is greater opportunity for learning. Interactive.	Frequently a high level of resistance. Hard to observe everybody's role plays, so they may misapply skills.

PAIR, SHARE AND DISCUSS

Purpose:

Provides opportunity for participants to process, discuss and evaluate information.

Advantages	*Disadvantages*
Provides opportunity for individuals who find it difficult to talk in a large group to share their ideas and be heard. Interactive, provides clarification.	Can take time. Less effective with a small group. May challenges participants who prefer lecture as opposed to sharing ideas.

QUESTIONS AND ANSWERS

ASKING QUESTIONS

Questions - are used to review information or draw upon the group's ideas and experience.

Closed questions – questions which generate yes/no or a short response. Not good for generating discussion.

- Identification questions – What kind of abuse is this?
- Selection questions – Which is more likely to be most effective, advocacy based counseling or motivational interviewing?
- Yes/No questions – Is that empowering?

Open questions – questions which generate more than a few words for an adequate answer. Good for generating discussion.

- Subjective questions – allow participants to express their own opinions, biases and experiences. What do you think about advocacy based counseling?
- Objective questions - are specific. What factors are necessary to develop a safety plan?
- Problem questions – present a situation and ask for discussion. What information do you need to know?

Phrasing

- Assume participants have the answer and want to share it – "Can anyone describe five signs of addiction" vs. "Who would like to describe five signs of addiction?"
- Don't make people read your mind and give you the "right" answer when you are trying to generate discussion. If you want discussion, ask a question. If you want people to learn a specific point, asking a question may not be appropriate. If you find yourself saying, "Those are really good points but what I was really thinking was,…" you may be asking questions inappropriately.
- Don't close with, "Any questions?" Rather say, "What questions can I answer for you?" and have closing remarks after answering all of the questions.

Overhead Questions – directed at the group at large without specifying a particular person.

Direct questions – asked of a particular person or group.

Allow time - for people to think about the answer to your question. Count to 10 before answering it yourself or rephrasing it.

ANSWERING QUESTIONS

You may not answer all of the questions asked of you:

- *Don't know the answer* – don't guess if you don't know the answer. Say, "I don't know. Let me find out and get back to you," or see if anyone else in the group knows the answer.

- *Reverse* – refer back to the person who asked. This is particularly useful when the person appears to be asking the question because they want to express their opinion. "That's a good question. What do you think?"
- *Redirect* – asked of the presenter and redirected to the group or a particular person. "That's a good question. Let's throw it out to the group. (or: Peggy, you've got a lot of experience in this area, what do you think? Carol's question is…"

DIFFICULT SITUATIONS

DOMINATOR

- Use direct questions to draw out other participants.
- Avoid looking directly at the person who asked the question.
- Tactfully interrupt the person with a statement such as:
    - "Peggy, I appreciate your in-put, let's hear what other people have to say on this topic."
    - "It's important to hear from everyone."
    - "Ann, I hate to interrupt you, but time is running out and I'd like to get the thoughts of some other people."

ARGUMENTATIVE

- Acknowledge concerns but point out time is limited and a complicated agenda needs to be completed.
- "I realize your concern on this issue and certainly don't want to minimize it, but we do have a lot of information to cover today.
- Keep a "parking lot" or list of questions to be answered later, e.g. individually, at the break for those who are interested, through the next scheduled training or through a handout provided later.

SIDE DISCUSSIONS

Assume that the conversation is on topic.

- Stop talking and wait for the discussion to stop. You may want to look at your notes to imply that the silence is to your benefit.
- Ask a direct question of a person who is sitting next to the people having the side conversation.
- Ask them directly if they want to share their ideas. "Peggy and Ann, it sounds like you have some ideas to share on the subject."
- Call one of them by name, re-state a point that was just made, and ask for their ideas on the subject.

NON-CONTRIBUTOR

- Ask questions when you know the person can speak with some conviction.
- Try Pair, Share and Discuss.

ANTAGONISTIC OR SKEPTICAL

- Anticipate and pre-empt objections. "I know that we all have full plates right now and you may see this as an unreasonable expectation but, when done properly, screening takes less than two minutes and can lead to improved health outcomes for your patient population."
- "Sounds like you have some concerns about this issue, let's talk about them."
- "I agree that in some situations, that makes sense. At other times another approach may get more favorable results. For example…"
- Interrupt and say, "Hold it a minute. Let's hear what the rest of the group thinks."

INTERRUPTORS

Look directly at the person and say, "Patti, I appreciate your contribution, but please hold it a moment; someone else was just making a point. When they finish we'll get back to you."

OFF TOPIC QUESTIONS/COMMENTS

Tact is important in this situation. Some possible approaches are:

- Apologize to the group: "I guess I haven't made the objective clear. Let me state it again."
- Tactfully ask the participant: "How does your comment/question tie in with the subject we are discussing," or "I'm not seeing the connection. Help me out…"
- Sidestep the comment/question: "That's a good comment/question, but it's on a little different subject. I wonder if we could discuss it after class."
- The "parking lot" (see Argumentative) is another place to store questions needing to be addressed later.

LEARNING STYLE DESCRIPTORS

Accommodator	**Diverger**	**Converger**	**Assimilator**
Dynamic Learner	*Innovative Learner*	*Common Sense Learner*	*Analytic Learner*
Gets involved	Imaginative	Experiments	Theories
Good at taking risks	Open-ended	Application	Collects information
Trial and Error	Sees things from many angles	Uses facts to build ideas	Looks for explanations
Uses others for ideas	Good at generating ideas	Good at making decisions	Industrious and thorough
Leadership	Likes identifying problems	Likes a single correct answer	Likes to know what experts think
Self-discovery	Creative	Problem solver	Observer
Variety, flexibility,	Emotional, social	Likes working with things	Likes working with data
Intuitive	Cultural interests	Practical	Likes traditional classrooms
Asks, "What can this become?"	Asks, "Why? Why not?"	Asks, "How does it work?"	Asks, "What is it?"
Role Plays, Large Group Discussions	Brain Storming, Debates, Small Group Discussion	Tools, Tip Sheets, Case History, Skills Practice	Recent Data, Cites, Bibliography, Trends, Charts, Graphs, Definitions

The above descriptors are adapted from David A. Kolb's **Learning Styles Inventory**, published by McBer and Company, Boston, MA.

MULTIPLE INTELLIGENCE CHECKLIST*

LINGUISTIC INTELLIGENCE

- Write well and enjoy putting thoughts on paper (or on computer).
- Enjoy telling stories or jokes.
- Can remember names, places, dates or trivia.
- Enjoy word games.
- Enjoy reading books and magazines.
- Am a good speller.
- Enjoy nonsense rhymes, limericks, puns, etc.
- Enjoy listening to the spoken word.
- Have a good vocabulary.
- Enjoy communicating by talking or writing.

Total number of check marks: _____

LOGICAL-MATHMATICAL INTELLIGENCE

- Ask questions about how things work.
- Can do arithmetic problems in my head.
- Enjoy math classes.
- Enjoy math games, e.g. computer math games.
- Enjoy chess, checkers or other strategy games.
- Enjoy logic puzzles or other brain teasers.
- Like to put things in categories or hierarchies.
- Like to use a variety of thinking skills to figure things out.
- Am good at thinking on an abstract or conceptual level.
- Clearly see cause-effect relationships.

Total number of check marks: _____

SPATIAL INTELLIGENCE

- Can visualize things clearly in my mind.
- Likes maps, charts and diagrams better than words.
- Often daydream.
- Enjoy artistic activities.
- Am good at drawing things.
- Like movies, pictures, and other visual presentations.
- Enjoy mazes, jigsaw puzzles, and Rubik's cubes.
- Can manipulate three dimensional drawings in my head.
- Frequently doodle or sketch.
- Enjoy creating designs on paper or by computer.

Total number of check marks: _____

BODILY-KINESTHETIC INTELLIGENCE

- Am good at sports.
- Fidget when asked to sit for very long.
- Am good at mimicking other's gestures.
- Like taking things apart and putting them back together.
- Like touching/holding objects and moving them around.
- Enjoy being on the go; running, jumping, moving, wrestling.
- Like working with my hands, e.g. sewing, repairing, making things.
- Use many gestures when expressing myself.
- Experience different physical sensations when thinking or working.
- Enjoy expressing myself through movement, e.g. dance.

Total number of check marks: _____

MUSICAL INTELLIGENCE

- Can distinguish among different sounds/tones.
- Remember melodies easily.
- Can carry a tune.
- Can play a musical instrument.
- Often hum or sing to myself.
- Am sensitive to noises, e.g. rain, traffic.
- Like doing things in a rhythmic way.
- Can hear music in my head.
- Enjoy reading music.
- Can keep time to a variety of music.

Total number of check marks: _____

INTERPERSONAL INTELLIGENCE

- Enjoy socializing.
- Am a natural leader.
- Am a good listener when friends/family have problems.
- Make friends easily.
- Enjoy clubs, committees, organizations.
- Like teaching things to others.
- Have many good friends, close acquaintances, and strong family ties.
- Am good at seeing another's point of view.
- Enjoy talking to groups.
- Enjoy exchanging ideas with others.

Total number of checkmarks: _____

INTRAPERSONAL INTELLIGENCE

- Know how to set goals and reach them.
- Clearly know my strengths and weaknesses.
- Am comfortable with myself and enjoy my own company.
- Feel good about who I am and what I stand for.
- Would be described as sensible.
- Stand up for what I believe.
- Am continually learning from my strengths and failures.
- Am not much concerned about fads, fashions, or what is "in."
- Am always honest about how I feel.
- Almost never feel bored.

Total number of check marks: _____

SPIRITUAL INTELLIGENCE

- Sense connections that transcend myself.
- Am aware of and true to my personal code of ethics.
- Try never to engage in behaviors that harm myself or others.
- Can be quiet and reflective.
- Am able to see beauty and wonder in nature and elsewhere.
- Seek to keep an open mind.
- Value my spiritual beliefs, and those of others, even if they differ from my own.
- Am in touch with my dreams.
- Realize I am never truly alone.
- Feel respect for those who came before me and for those who will follow.

Total number of check marks: _____

This checklist is adapted from one developed by Thomas Armstrong, which appears in Multiple Intelligences in the Classroom, a 1994 publication of the Association for Supervision and Curriculum Development, Alexandria, VA. The notes entitled "Seven Intelligences of Howard Gardner," to follow are from the same publication. Note: Section on Spiritual Intelligence was added to the above checklist by P. Bland, 1997, to reflect issues addressed in chemical dependency counselor training.

Seven Intelligences of Howard Gardner *(From "Multiple Intelligences in the Classroom," by Thomas Armstrong, 1994)*

According to Gardner, all people possess at least seven distinct sets of capabilities – or intelligences – which work in concert, rather than in isolation.

Linguistic: The capacity to use words effectively, either orally or in writing. It includes such things as the structure of language, the sounds of language, the meanings of language, and the practical uses of language. This type of intelligence is highly developed in story-tellers, orators, politicians, poets, playwrights, editors and journalists.

Logical-Mathematical: The capacity to use numbers effectively and to reason well. It includes sensitivity to logical patterns and relationships, statements and propositions (if-then, cause-effect), and other related abstractions. This type of intelligence is highly developed in mathematicians, accountants, statisticians, scientists, computer programmers and logicians.

Spatial: The ability to perceive the visual-spatial world accurately and to perform transformations upon one's perceptions. It involves sensitivity to color, line, shape, form, space and the relationships between these elements. It includes the capacity to visualize, to graphically represent visual or spatial ideas and to orient oneself appropriately in a spatial matrix. This intelligence is highly developed in hunters, scouts, guides, interior designers, architects, artists and inventors.

Bodily-Kinesthetic: The ability to use one's whole body to express ideas and feelings, and facility in using one's hands to produce or transform things. It includes specific physical skills such as coordination, balance, dexterity, strength, flexibility, and speed as well as tactile capacities. This intelligence is highly developed in actors, mimes, athletes, dancers, crafts persons, sculptors, mechanics, massage therapists, and surgeons.

Musical: The capacity to perceive, discriminate, transform, and express musical forms. Included here are sensitivity to rhythm, to pitch or melody, and to timbre or tone color. This type of intelligence is highly developed in musical performers, composers, aficionados, and critics.

Interpersonal: The ability to perceive and make distinctions in the moods, intentions, motivations and feelings of other people. This intelligence can include sensitivity to facial expressions, voice, and gestures as well as the ability to respond effectively to such cues – to influence other people, for example. Effective counselors, salespeople, teachers and politicians have developed this intelligence.

Intrapersonal: The ability to act adaptively on the basis of self-knowledge. This intelligence includes having an accurate picture of one's strengths and limitations, awareness of one's moods and motivations, an understanding of one's temperaments and desires; and the capacity for self-discipline, self-understanding, and self-esteem. This intelligence is highly developed in individuals who are described as "having their act together."

EDUCATIONAL TAXONOMIES

Cognitive Domain By Benjamin S. Bloom, 1956	**Affective Domain** by David Krathwohl, 1956	**Psychomotor Domain** by R.H. Dave, 1970
Knowledge: • Involves recall or recognition of specific facts. • Focus is on remembering. • TV Game shows, Trivial Pursuit & many "objective" tests focus on this type of learning. *"What do I know"*	**Receiving (attending):** • A willingness to receive or attend to phenomena and stimuli. • Learner is passive, but attentive and listening with respect. *"I'll at least hear what the person has to say"*	**Imitation:** • Observing and patterning behavior after someone else. • Performance may be a low quality. *Example: Copying a work of art*
Comprehension: • Involves putting knowledge in a different form by paraphrasing, summarizing, interpreting, or inferring. • It represents the lowest level of understanding because a person can use the information without seeing the big picture. *"What does this mean?"*	**Responding:** • A willingness to commit at least in some way to participate in the given activity. • Learner reacts as well as showing awareness. *"I'm not sure why we're doing this but I'll give it a try."*	**Manipulation:** • Being able to perform certain actions by following instructions and practicing. *Example: Creating work on one's own, after taking lessons or reading about it.*
Application: • Involves using knowledge in new, not previously learned ways. • Requires the ability to use abstractions in concrete situations. • Seeing relationships/ connections is an	**Valuing:** • Acknowledging that something has worth. • Learner willingly displays behavior consistent with a belief or attitude.	**Precision:** Refining, becoming more exact. Few errors are apparent. *Example: Working and re-working something so it will go "just right."*

important skill to have. *"How can I use what I know in different situations?"*	*"I can see the importance of this and embrace it as something I need or want to do."*	

(Page 2 of 3: *Educational Taxonomies, continued)*

Cognitive Domain By Benjamin S. Bloom, 1956	**Affective Domain** by David Krathwohl, 1956	**Psychomotor Domain** by R.H. Dave, 1970
Analysis: • Involves breaking material down into its constituent parts, seeing how the parts are related, and being able to explain these relationships. *"Why does this work as it does?"*	**Organization:** • Beginning to develop an internally consistent value system. • Seeing how values are interrelated, and being able to establish priorities. *"Doing this assignment will mean missing my favorite TV show, but in the long run developing these new skills will be much more important than my being entertained right now."*	**Articulation:** Coordinating a series of actions, achieving harmony and internal consistency. *Example: Producing a video that involves music, drama, color, sound, etc.*
Synthesis: • Involves putting together elements and parts into a new pattern or structure that were not there before. • It is the category in the cognitive domain that most clearly provides for creativity. *"What can I create from the information and ideas I have?"*	**Characterization:** • Acting consistently in accordance with internalized values to the point that: 1.) We are described and characterized as having specific pervasive tendencies and behaviors 2.) These beliefs, ideas and attitudes are integrated into a total philosophy or world view. *"I want to be known as Ms. Non-Judgmental."* *"I want my epitaph to read, 'developed services for chemically dependent battered women.'"*	**Naturalization:** Having high level performance becomes natural, without needing to think much about it. *Examples: Michael Jordan Playing basketball, Nancy Lopez hitting a golf ball, etc.*

Cognitive Domain By Benjamin S. Bloom, 1956	**Affective Domain** by David Krathwohl, 1956	**Psychomotor Domain** by R.H. Dave, 1970
Evaluation: Involves using criteria and standards to make judgments about the value of ideas, works, solutions, methods, materials, etc. *"Is this accurate, useful, effective, economic, satisfying?*		Education programs should address levels of learning as well as the content being learned. When concerns about unmotivated participants are raised, the real issue is often the level of learning taking place.
		Participants who don't know why they are learning something (poor context) probably have a difficult time valuing it, which may mean they spend little time on refinement, exactness and precision.

Five Incorrect Assumptions about Learning

(The following information is from The Double Helix of Education and the Economy published by Teachers College Press, Columbia University, in 1992. The authors are Sue E. Berryman and Thomas R. Bailey)

Assumption One

People predictably transfer learning to new situations.

Accepting this assumption requires us to confront what is known as "knowledge transfer problem." Knowledge transfer simply means the appropriate use in a new situation of concepts, skills, knowledge, and strategies acquired in another.

Extensive research spanning decades shows that individuals do not predictably transfer knowledge in any of the three situations where transfers should occur. They do not predictably transfer school knowledge to everyday practice. They do not predictably transfer sound everyday practice to school endeavors, even when the former seem clearly relevant to the latter. They do not predictably transfer their learning across school subjects.

Assumption Two

Learners are best seen as passive vessels into which knowledge is poured.

Many people think of schooling as the transmission of "canonical" knowledge—in other words, of an authoritative, structured body of principles, rules and knowledge. Education as canonical transmission thus becomes the conveying of what experts know to be true, rather than a process of inquiry, discovery and wonder. This view of education leads naturally to the student as the receiver of the word and to the teacher as the controller of the process.

The assumption that the teacher is the pourer and the student the receptacle has several unfortunate consequences. 1.) It reduces or removes chances for exploration, discovery and invention. Students need chances to engage in choice, judgment, control processes and problem formation. They need chances to make mistakes. 2.) It places control over learning in the teacher's not the learner's hands. Passive learning creates learners dependent on teachers for guidance and feedback, thus undercutting the development of confidence in their own sense-making abilities, their initiative, and their cognitive executive skills.

Assumption Three

Learning is the strengthening of bonds between stimuli and correct responses.

American education reflects a behaviorist theory of learning—a view that conceives of learning as strengthening of bonds between stimuli and the learner's responses to those stimuli. This psychological theory has had three major effects. It led to the breakdown of complex tasks and ideas into components, subtasks, and items that could be studied and examined separately. It encourages rote and routine learning and repetitive training. And it led to the focus on the "right answer" and to the counting of correct responses. The result was fractionation: having to learn disconnected subroutines, items, and sub-skills without an understanding of the larger context into which they fit which gives them meaning. Fractionated instruction maximizes forgetting, inattention and passivity. Information currently available to us indicates that learners of all ages seem to learn better in complex and meaningful environments.

Assumption Four
What matters is getting the right answer.

An instructional focus on the right answer discourages instruction in problem solving. Facts are important, but by themselves constitute an impoverished understanding of a domain. A fact focus does not develop students' ability to think about the domain in different ways. When the focus is on the right answer, students resort to veneers of accomplishment. Their concern is about what the teacher wants, or what will be on the test, rather than on how they can improve their learning. Furthermore, while students who get the right answer appear to be learning, teachers often fail to check behind the answers to insure the students really grasp the principles that they are expected to master. Finally, when the right answer is emphasized, neither teachers nor students view wrong answers as learning opportunities. Rather they view them as failures.

Assumption Five
To insure their transfer to new situations, skills and knowledge should be acquired independently of their contexts of use.

Context is critical for understanding and thus for learning. This means the learning must be coherent and interpretable, and must come out of the experiences of those doing the interpreting, i.e. the students. Part of good teaching is to present information in a context that generates meaning for students.

5 Incorrect Assumptions about Learning prepared by Cal Crow, Ph.D., Center for Career and Work-Related Education. Highline Community College, 25-5A, P.O. Box 98000, Des Moines, WA 98198-9800. Phone 206-870-3783 / Fax 206-870-3787 / E-mail: nwcooped@halcyon.com *11/16/95.*

APPENDIX

Training Activities: Roles in Group Discussions

Discussion Leader

Your job is to keep the group "on task." If the discussion wanders off the topic, encourage participants to return to the task. If a person's contribution confuses you, ask for clarification. Feel free to make contributions to the discussion also.

Recorder

Your job is to capture the main ideas that are presented in the group discussion. Write down each contribution on paper to verbally report back to the group. Try to use the exact words spoken by each contributor. If contributors are very-long-winded, ask them to summarize their point in one sentence. If you would like to make a contribution please do! Be sure to record it also.

OR

If poster board or flip chart paper is provided by the training facilitator, record comments in brief form. Print legibly. Make sure the lettering is large enough to be read by others in the group when the notes are posted on the wall or flip chart. NOTE: You may need to get help to post the pages in full view of the group.

Timekeeper

Your job is to watch the clock. Remind the group of how much time they have left. If several points need to be covered, or several tasks need attention, get the group to agree on how much time they want to devote to each step of the task. If the group seems to be running out of time on a particular point, do interrupt, and ask the group members how much time they want to use, to finish the step on which they are now working. Feel free to contribute to the group discussion yourself.

Participation Encourager

Your job is to make sure that everyone has an opportunity to offer a contribution, and to make sure that people do not interrupt each other. You should feel free to contribute to the group discussion yourself.

TRAINING LOGISTICS

Date	Training type?	Contact Person	When/ Where?	Trainer(s)	Community Liaison	Equipment needed?	Who's Driving?	How Many Attending?	Hand-outs ready? ✓ if yes

SAMPLE TRAINING LOGISTICS GUIDE

PART I

1. Identify site to receive initial training.
    a) Target by community need, interest expressed by agency or local community service provider, etc.

2. Create a folder for each site to be contacted. Document each contact, whether it is by phone, fax, in writing or face to face.

3. On each folder indicate the following:
    a) Training site name, address, phone and fax numbers, email address.
    b) Training site manager name and phone number as well as your contact if different from the manager.

4. Once a training is scheduled include the following in the file:
    a) Directions to the training site and room # or location of the training.
    b) Contact name and phone number of person who will be present day of training should questions or problems arise. This person will also be responsible for helping the trainer collect sign-in sheets and evaluations.
    c) The number of people to be trained and, when applicable, background on the participants e.g. Are they all doctors ?Mental Health Providers? Community leadership? Mix of employees? Legal? Law Enforcement? Educators? Clergy?
    d) Indicate whether the participants to be trained have indicated a particular area of interest for example :Legal Remedies? DV/SA 101? Screening in a Medical Setting?
    e) Note technical training needs and whether training site has overhead or slide projector, TV-VCR, laptop, PowerPoint projector, audio equipment (including microphones) white board , blackboard or paper and easel as well as writing implements such as markers or chalk?
    f) If above is unavailable advise trainer to bring paper, markers and tape or portable overhead/slide projector or other equipment as needed.
    g) If doing a training over an hour be sure to consider at least some video or audio clips and request a VCR. Document your plans in the file. Plan to arrive early to check on your technical equipment and make sure it is working and READY FOR USE. Always have a back-up plan.
    h) Indicate whether or not participants will be eating a meal during training so that the trainer can factor in how much time to allocate for participants to eat before passing out pre/post tests etc.
    i) Indicate name of trainer responsible for training.
    j) **All training should include both an advocate and someone from the community, most often someone drawn from the place you are training**.

k) Be sure to schedule time to discuss in-put from community partner prior to training. When training is scheduled indicate name of community partner who will co-train with the advocate.

5. Note in file whether this is first, follow-up or repeat training. Also indicate any special information which would be of use to the trainer, i.e. health care staff want advanced documentation training, teachers are interested in substance abuse issues and DV/SA, community wants training on working w/special population.

6. When training is scheduled send a confirmation letter or e-mail to your contact at the training site with all pertinent details summarized. A copy of this letter/email should be sent to your co-trainer as well.

7. Following initial training, training site contacts should be contacted re: follow-up meetings to discuss how the training went and other training or community service goals or issues. A copy of training materials or brochures should be mailed to the training site manager and interested parties who may not have been able to attend your training. Additionally, encourage participants to explore volunteer participation in our programs. Make every effort to foster a relationship between the DV/SA program and the community agency you are providing training for.

8. Training sites should be placed on a booster schedule and appropriate flyers and program information should be mailed to them several times a year *(every three months is often a good schedule)*. Booster material may include: screening cards, pens, dv buttons, posters etc.

9. A tickler file should be created to remind you to contact programs you have trained in the past so you can maintain your connection and prevent relationships from slipping through the cracks. Determine whether staff need more advanced or specialized training. Schedule additional training as needed. Make phone calls to see how your training contact is doing. Encourage linkages between DV/SA and other community programs.

10. Whenever a training site receives training, check to see if they want to put information about the training in their newsletter or report it in the local press.

11. Trainers need to be prepared prior to arriving at a training site. They are responsible for having a proper number of handouts with them as well as brochures and information unless the training site agrees to make the handouts. Also before leaving to provide training, trainers should ask themselves: Do you have directions to where you are going, your video, overheads or disc and projector? Do you have enough pencils, markers, a sign-in sheet, a driver if

necessary, tape, large sheets of paper, posters, etc? Additionally, has the trainer found interesting articles or facts to supplement the basic curriculum? Another option is to assemble a list of additional articles for the training participants to explore on their own

12. Routinely check on supplies on the 1st Friday of each month:
    a.) Folders b.) Brochures c.) Safety Plans d.) Books e). Pamphlets f.) Other materials e.g. pencils etc. g.) Update your training calendar weekly

PART II - Overview

Tips below from *Developing a Domestic Violence Training Initiative: Technical Assistance Manual*, Volume I, by Linda Chamberlain Ph.D. See web page: http://www.hss.state.ak.us/DPH/mcfh/akfvpp/training_v2s2.htm

1) Make sure your philosophy and goals are crystal clear. Acknowledge conflicting goals and policies and find common ground. Be prepared for conflict. Have strategies for participants to get past the past but realize that painful things may need to be said before people can move on and be productive.
2) Be flexible and support a community initiated approach. Do it the way communities want it. Provide avenues for local control and decision making such as local planning committees.
3) Be inclusive. People who you may not expect to want to be part of this effort may start coming once the word gets out.
4) Don't be surprised if the obvious stakeholders do not join initially. People who you expect to join in may tell you that DV/SA is not their priority. Their absence may distort perceptions regarding why they are not at the table.
5) Expect raw emotions. Talking about family violence triggers emotions. Talking about the relationship between DV/SA and child abuse creates even more tension and grief. Prepare agency contacts and other speakers for the possibility of tension or conflict and that emotions may be directed at them. Provide opportunities for debriefing. Examples of common emotional reactions may include: a.) Anger: "Why has it taken so long for you to talk about this?" b.) Unresolved pain and grief: "Nobody ever helped me…" c.) Fear: "What have I done to my children?"
6) Spend time on role clarification and names and faces. Even in small communities people often don't know who does what. Be ready to come back—don't start something you can't finish. You have planted the seed, now will you continue to help your community?
7) Tie-in new science. Recent research can help people see the big picture.
8) Build in fun. Amidst the pain, grief and frustration that often occurs during these workshops, there needs to be time for celebration and relaxation. Cultural events can be a wonderful way for people to share and learn about one another while honoring diversity.

ANDVSA Domestic Violence Sexual Assault Basic Curriculum – Role Plays

(Trainer assigns roles to victim, perpetrator, screener, observer or other e.g. child, interpreter, advocate etc., as needed. Persons playing roles (except screener) should read slip. Observer or trainer should furnish screener with basic facts (e.g. 1st visit, established patient, walk-in) and what the presenting problem or concern is. Assume the immediate presenting problem has been addressed and some rapport has been established. Have provider screen for DV/SA. When assigning role-plays trainer should furnish players with backgrounds reflective of diversity found within population served. These modifications can be jotted down on the lines provided below the role-plays. This technique allows trainers to vary role-plays adding from an endless list of human variables.)

You are a new patient today presenting with general, "not feeling well," headache and nausea. No specific ailments but you think you might be pregnant and are upset because you are not allowed to use contraception. You are married and are accompanied by your spouse who is in the lobby. Your spouse has been emotionally and sexually abusive to you for the past two years. Do not disclose abuse. Give vague response to screening questions.

(Sample: Victim is Russian immigrant, does not speak English; abuser is American)

You are seeing a counselor today. You have a four-year-old daughter who is with you this afternoon. The presenting problem is depression and sleeplessness. You are living with a partner who is physically abusive. You have a past history of "falling," and once showed up to see your counselor with a broken arm and bruised shoulders following the "fall." You currently have bruises on both arms from your partner who tried to prevent you from leaving the house yesterday. Initially disclose some domestic violence following screening but then recant and refuse to discuss it.

You are a walk-in client at WIC today with concerns about nutrition. Tell the receptionist your husband might be calling to see what time you got there. You have never experienced physical violence however your husband has threatened to kill your cat if you gain any more weight. Tell the WIC worker your husband wants you to stop breast feeding your 3-month-old baby and ask her how you can lose some weight. Be evasive when screened about DV/SA.

You are here for an OB appointment (30 weeks along). Your spouse has been both mentally and physically abusive. Your spouse accompanies you into the room. He answers for you and does not let you speak. You wish to seek help. Ask to go to the bathroom. Once out of the room, tell the provider about the problem. While you are talking to the provider your spouse appears and interrupts you.

You are six months pregnant and have received sporadic prenatal care. You are a cigarette smoker and you are hiding a drinking problem. Your partner constantly criticizes you and puts you down. Once you went to an AA meeting but your partner accused you of trying to pick up men. It is easier to drink than listen to him when you are sober. The last three weeks he has been waking you up at 2 a.m. complaining about the way you sleep when he is awake. You are exhausted and worried about the drinking and have showed up here to ask the social worker what you need to do to get vitamins when you don't have any money. You don't consider your partner's behavior abuse because you don't get hit and would not tolerate that. Argue with screener (at least initially!). Your partner is in the car.

Part 1
You do not speak English. Your mother-in-law has accompanied you to your appointment. You are here for a well-baby visit. Your baby is six weeks old and not eating well. You have a faint bruise under your eye. Your mother-in-law says she is here to interpret. Mother-in-law gives screener a hard time about getting an interpreter.
Part 2
Next visit you arrive at office for routine immunization for baby and you see interpreter present for this appointment. She is friend of your husband's sister. Your bruise is completely gone. Deny domestic violence to screener.

DFYS has received a report from your child's teacher that your 7 year old child appears neglected. You are in an abusive relationship. You live on and off with your partner. You also have two children ages 5 and 3 and are pregnant with your fourth. Your partner has hit you in the past. Lately the violence has been increasing in both severity and frequency and your partner is yelling all the time. You live in an isolated rural area. You are in a dangerous situation and are afraid to answer questions about DV/SA. When asked screening questions by a home visitor from DFYS you become belligerent and ask why you are being asked these questions.

ANDVSA Domestic Violence Sexual Assault Basic Curriculum
Group Exercises-Scenarios

Scenario: A 17-year old_____ girl is accompanied to her appointment by her live-in boyfriend who is waiting for her in the reception area. She is 3 months pregnant. On examination you notice bi-lateral bruising on her arms, and a bruise on her thigh. *(Fill in blank with descriptor reflecting diversity of population seen at your program e.g. Deaf, Chinese, East Indian, Latvian, run-a-way, etc. the list is endless.)*

1. What do you want to assess and screen for?

2. What questions do you want to ask her?

3. What course of action might you take or recommend?

4. Identify barriers to services, options and steps to take if she:
   a. Does not speak English

   b. Has low or no income or comes from a wealthy background

   c. Says there is no domestic violence

5. Describe case documentation:
   a. Identify key elements to include in chart

   b. Cite referral resources

   c. List steps to maintain patient safety and confidentiality

Scenario: A 34 year old_____ woman is here today with a presenting problem of depression. Her husband, who canceled her last three appointments, has come in with her today. This charming man accompanies his wife and expresses concern about her depression. He also mentions she has headaches. You ask about her headaches and also express concern. She is pregnant and has a 4 year old boy. She says very little and generally looks to her husband to respond. He answers all the questions for his wife. There are no visible indicators of physical abuse. *(Note: Fill in blank with descriptor reflecting diverse population seen in your program e.g. Jewish, Native-American, Russian, Alaska Native, Deaf, Cambodian, Ethiopian, Recovering or Addicted, Homeless, etc.…the list is endless)*

1. How will you manage to get 10 minutes alone with this woman?

2. What would you say to her? Identify barriers that may need to be addressed as well referral options.

3. Identify concerns you might have and possible responses if the woman:
   a. Is deaf

   b. Thinks she could get deported if her husband gets 'mad'

   c. Has insurance coverage through her husband's plan and he doesn't think she needs to come in for every little thing

   d. Hopes her new baby won't upset her husband like the four year old does

   e. Asks if it is OK to have a glass of wine to unwind when you are pregnant?

4. Describe follow-up and documentation if you suspect domestic violence/sexual assault but are unable to confirm it.

Scenario: A 26 year old_____ woman arrives for a WIC appointment three weeks after having given birth to a low birth weight baby. She says she would like to breast feed but her partner won't let her. During your conversation the woman cries and mentions she is tired and sore. She says the baby keeps her up nights but her partner is even worse, "Like I want to be with that one morning, noon and night...." She also expresses concern about her weight saying, "Pat's gonna put me on a diet if I don't shape up fast." *(Note: fill in blank with descriptor addressing diversity in your program e.g. MICA, Muslim, Latina, Irish-Catholic, African-American, Lesbian, Bi-sexual, Transgendered, etc. the list is endless)*

1. How would you respond?

2. What do you want to screen and assess for? What referrals would you make if Pat is a woman?

3. How can you offer empowering options, support and validation without 'telling' the woman what to do? Discuss reasons to support woman's right to choose whether to contact police or seek a Protective Order.

5. What steps could you take to address the nutritional and safety needs of:
   a. The mother

   b. The child

6. a. Can you identify potential risks re: this woman's reproductive health or personal safety that might be reduced by referral to a battered women's advocacy program, a sexual assault program, an alcohol drug treatment program and/or to a health care or mental health provider knowledgeable about domestic violence, sexual assault, substance abuse and postpartum depression? Under what circumstances would a DFYS referral be necessary?

   b. How could you support the coping skills this woman already possesses?

Scenario: You arrive at the home of a 19-year old _____ mother of 16 month old twins. She is 3 months pregnant with her third child. DFYS became involved with Rita when her twins tested positive for cocaine at birth. 3 months ago Rita completed chemical dependency treatment. She has been re-united with her twins for the past 6 months and two weeks ago moved out of a supported living situation and into her own apartment. Rita says she is not sure who the father of her new baby is. Her ex-boyfriend (the father of the twins) is in jail. He will be released in 30 days. She is currently seeing a new person she met at an NA meeting. She says no one is home but you smell cigarette smoke from another room and notice a man's pair of shoes under the kitchen table. You had hoped to see the twins but Rita says she forgot you were coming and they are at her sister's and "Doing just great!" *(Note: fill in blank with descriptor addressing diversity in your program).*

1. Will you screen for domestic violence/sexual assault today? Why or why not?

2. When you do screen for DV/SA?
   a. What concerns do you have? What info do you need?
   b. If she discloses abuse, describe potential safety risks and health care risks.
   c. How and where will you address the topic of abuse?
   d. How do you triage competing concerns?

3. Discuss steps you can take to reduce risk and address safety :
   a. For the woman
   b. For the twins
   c. For the fetus
   d. For yourself

4. What are your local community resources and who are your community partners? How can they provide support to the woman? Her children? You?

5. What plan can you put in place if you need to defer screening during this initial home visit?

6. You remind yourself it is not your job to cure DV/SA but you find yourself angry because the woman won't do what you think is best. What steps can you take to support the woman through the process in an empowering way? What steps can you take to avoid burn-out?

Questions Most Frequently Brought up by Healthcare Professionals During Domestic Violence Training

(This material was excerpted from the manual entitled *"The Perinatal Partnership Against Domestic Violence Manual, 2001, Department of Health Maternal- Child Health* . This section entitled "Questions and Responses" was developed for the WSCADV by Patricia J. Bland, M.A. CCDC, Leigh Nachman Hofheimer, M.A. and Candy Cardinal, MSW and is reprinted here with permission from the Washington State Coalition Against Domestic Violence.)

1. There is not enough time for me to routinely screen all of my female patients for domestic violence.

Trainer's Response
Usually this comment comes up because healthcare professionals feel rushed for the time they are able to spend with each patient. In many clinic settings, the provider is scheduled to see patients every 15 minutes. There might be fear on their part that the screening and intervention will take too much time. Another fear may be they are afraid the patient may break down and require a great deal of time to console her. Helpful responses from the trainer could be:

- The assessment and intervention takes no more than 5 minutes of your time.
- Perhaps the medical assistant could ask the routine screening questions while blood pressure is being checked. If the patient screens positive for domestic violence, the provider could do the follow up intervention.
- If the patient does become upset and feels she needs to tell her complete story, tell the patient, "I see how upset you are and want you to get the best possible help available. This is not your fault and I'm sorry this has happened. I am not an expert on domestic violence but I do know of a great resource in the community (Name your local domestic violence victim service provider.) We can call the hotline now and you can talk with an advocate about your situation in private. Does this sound like a good option for you? I will check back with you in a few minutes, okay?"

2. Why do I need to screen all my female patients? I don't think it is necessary.

Trainer's Response
Usually this question comes up when providers are not familiar with how prevalent domestic violence is. They may have misconceptions about who is a victim of domestic violence. Helpful responses from the trainer could be:

- Talk about the prevalence of domestic violence:
  "One in four women will experience domestic violence in their lifetime. This is twice the rate of breast cancer."
  "Domestic Violence is more prevalent than pre-eclampsia, gestational diabetes and placenta previa."

- Remind them domestic violence knows no boundaries and affects people from all ages, races, socio economic, and education levels.

3. I get really frustrated and feel like I am not being effective because she keeps:
Denying abuse even though I know she is being hurt.
Minimizing the abuse.
Doing nothing about her situation, stays in the relationship, keeps going back.

Trainer's Response
You will hear this in training partially because healthcare professionals are trained to "cure" or "fix" a person's problems. They get frustrated when this doesn't happen. Also, they may not yet fully understand leaving an abusive relationship is a process. Helpful responses from the trainer could be:

- Acknowledge and normalize their frustration.
- Remind providers the goal of screening for DV is not to have women answer YES to the question . . . The goal is simply to ask the question and begin planting seeds for change. ASKING THE QUESTION IS THE INTERVENTION!
- Remind providers leaving is a process. They may not know where in the process the woman is at.
- Providers can share their concerns with the patient, offer some DV education and let the patient know about local DV resources. This way the patient will be aware of her options and feel supported as she goes through the process of finding safety.

4. What happens if she denies abuse if taking place but I know she is not telling me the truth?

Trainer's Response
This is a common question that comes up in training. If no one brings it up, I usually do as the trainer. Helpful responses could be:

- Have the provider respond this way; "I'm glad you're not being hurt by your partner. Domestic violence is a health problem for so many women in my practice that I always inform my patients it is safe to talk about abuse here. We have resources for help should you ever need them."
- Remind providers they can gently share their concerns about abuse with their patient. When a patient has multiple clinical indicators for domestic violence, especially injuries, they can say, "I am concerned about your injuries. When I have seen injuries like this in the past, they have many times been caused by an intimate partner. I want you to know anything you share with me is confidential. Also, my job is not to tell people how to live their lives but to talk about options, safety, and resources for help."

5. Why are we routinely screening female patients and not routinely screening male patients for domestic violence? After all, men are victims too.

Trainer's Response:
As victims' advocates, we all know how frustrating this question is, but it is a question that gets asked. We have developed ways to address this issue in training. Helpful responses could be:

- Early on in training when you are talking about prevalence let them know there are male victims, many who are in gay relationships. Acknowledge the rare occasions where a male victim has a female perpetrator. Let providers know, in Washington State, male abusers committed 90% of the DV homicides reported in 1999. Frequently you will hear the statement, "But a man would never tell if it was happening to him." Respond by stating, "It has been my professional experience victims are reluctant to disclose abuse regardless of gender. Abuse is unacceptable in any form." Remind them we are screening all females because the prevalence of DV in this population is higher than that of breast cancer, however; the screening tools we teach them are relevant regardless of gender.

6. I am not comfortable in my knowledge and ability to provide intervention if she says yes to the screening question.

Trainer's Response
There is a simple response to this issue:

- Advise providers they do not have to be the expert on domestic violence. There are DV experts in our community doing this work every day. Providers are used to asking tough questions and just need to feel comfortable enough to "ask the question" and know how to respond. The best response if she says 'yes' or 'maybe', is a referral to your local battered women's program.

7. What do I do if she says she is not safe to leave the clinic today and her abuser is in the waiting room looking and acting very impatient?

Trainer's Response:
This is every provider's biggest fear. Helpful responses could be:

- Tell the provider to call the domestic violence hotline for either consultation or to connect the patient directly with the hotline. Remind providers they don't have to fix this problem. Battered women's advocates are experts in the community who have more experience safety planning with victims.
- Remind providers the best safety planning option may be leaving with the abuser today and moving forward with implementing different safety planning options, i.e. tomorrow when partner goes to work, tonight when partner goes out with his friends, etc . . .

8. It is too difficult to remove the partner from the room to screen for domestic violence.

Trainer's Response:
There may be many reasons why this comes up. Providers may not be interested in screening for domestic violence and use this as an excuse. There may be departmental/clinic philosophical reasons why this is difficult. (i.e. A department/clinic has a strong "family centered" way they provide care for patients. Support people are encouraged to play an active role with the patient, which can include being part of all office visits.) They also may have fear around how they will get the partner out of the room so they can screen for domestic violence. Helpful responses include:

- If they are putting this up as a barrier because they do not want to screen for domestic violence, remind them screening is the right thing to do. Remind them of the prevalence of domestic violence. If it is hospital/clinic policy that screening occur, remind them of this and of liability.

- If there are philosophical differences, remind providers of the importance of screening and the prevalence of domestic violence. Encourage them to think of moments when the patient may be alone making screening possible i.e. when partner is in the bathroom, left for the evening, out smoking or eating.

- If there is fear around getting the partner out of the room, encourage them to think about creative solutions. Some of these include telling the partner "This is the time in the appointment that is private for all my patients. I need you to wait in the waiting room. Consider asking partner to fill out paperwork in the reception area. Another alternative is to work as a team. Have the receptionist pull the partner out of the room to discuss "insurance" while the provider does the screening.

- Remind providers they are probably asking people to step out frequently already. When asking a possibly abusive person to step out be sure to give the impression you do this with all your patients. When security is available advise them an abuser is on the premises.

- Remind providers when all options for removing a partner are exhausted screening cannot take place while potentially abusive partner is present. At the next visit the team will have to work together to keep the partner out of the room so screening can take place.

9. I am afraid I will offend my patients if I ask them about domestic violence.

Trainer's Response
This is a comment that is brought up often. Helpful responses include:

- It has been my experience this rarely occurs. Should a patient become angry state, "I am sorry if I have offended you. That was not my intention. I am not singling you out or trying to label you in any way. It is this clinic's practice to ask all our female patients about safety in their relationships because it impacts a woman's health. This clinic is a safe place to talk about abuse and we have resources to help."

Understanding Domestic Violence:

PREPARATORY READING FOR PARTICIPANTS

By Anne L. Ganley, Ph.D.

INTRODUCTION

Domestic violence is a widespread societal problem with consequences reaching far beyond the family. It is conduct that has devastating effects for individual victims, their children, and their communities. In addition to these immediate effects, there is growing evidence that violence within the family becomes the breeding ground for other social problems such as substance abuse, juvenile delinquency, and violent crimes of all types. The presence of domestic violence is particularly relevant to issues that arise during a family preservation intervention.

In order to most effectively and efficiently respond to individuals experiencing domestic violence, family preservation practitioners must not only understand the nature and etiology of domestic violence, but also understand how violence against intimates affects the victims, perpetrators, children, and community as a whole. This chapter provides the framework for that understanding of domestic violence by reviewing the definitions, causes, and issues related to victims, children, and perpetrators of domestic violence. Understanding the what, why, and who of domestic violence enables practitioners to intervene in a manner that ensures the safety of all family members, thus enabling effective parenting to take place in a *safe* and secure environment.

I. BEHAVIORAL DEFINITION OF DOMESTIC VIOLENCE

Domestic violence goes by many names: wife abuse, marital assault, woman battery, spouse abuse, wife beating, conjugal violence, intimate violence, battering, partner abuse, and so forth. In addition to different terms or labels, there are varying definitions of domestic violence. A clinical or behavioral definition of the problem is often different from and more comprehensive than its legal definitions. These different terms and definitions can lead to inconsistencies in the identification and assessment of domestic violence, and in intervention and research into domestic violence.

For the purpose of this training manual, a behavioral rather than a legal definition of domestic violence is used. In this behavioral definition, domestic violence is defined:

1. by the relationship context of the violence

2. by the function the abuse serves

3. by the specific behaviors of the perpetrator

The terms that will be used interchangeably in this manual to refer to the problem are domestic violence, abuse, and battering.

DEFINITION OF DOMESTIC VIOLENCE

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

A. Relationship Context[1]

Domestic violence occurs in adult or adolescent intimate relationships where the perpetrator and the victim are currently or have been previously dating, cohabiting, married or divorced. They may be heterosexual, gay, or lesbian. They may have children in common or not. The relationships may be of a long or short duration.

The intimate context of the abuse influences how both the perpetrator and victim relate to and are affected by the violence. Behaviorally, battering may look to an outside observer like stranger-to-stranger violence (e.g., simple assault, aggravated assault, homicide, sexual assault, harassment, kidnapping, hostage-taking, stalking, property damage, arson, menacing). Victims of domestic violence are traumatized in many of the same ways as victims of violence perpetrated by strangers. However, in domestic violence cases the trauma is a repeated rather than a singular event and the effects of the trauma are accentuated due to the intimate nature of the relationship between victim and perpetrator. Unlike the attacker in stranger violence, the domestic violence perpetrator has ongoing access to the victim, knows the victim's daily routine, and can continue to exercise considerable physical and emotional control over the victim's daily life. His relationship with the victim gives him social, if not legal, permission to use such abuse. Unlike victims of stranger violence, victims of domestic violence must also deal with the many barriers to separation from the perpetrator created by the complexity and strength of an intimate relationship.

While domestic violence has certain similarities to the other forms of family violence - child abuse, child-to-parent violence, sibling violence, and abuse of the elderly - it has certain unique characteristics which make it a distinct category. In domestic violence, the perpetrator and victim are in an adult or adolescent intimate relationship, where both are supposedly peers with equal rights and responsibilities within the relationship. Neither has a legitimate role for disciplining or controlling the other. Domestic violence is a distortion of that relationship of equals.

Domestic violence, as defined in this manual, does not technically include child abuse or neglect since the nature of the relationship between parental perpetrator and child victim is different from adult or adolescent perpetrators and their intimate adult or adolescent victims.

However, in some domestic violence cases, children may also be targeted as victims, and thus there may be child abuse and/or neglect as well as spouse abuse in a particular family. In other cases, the children may not be the targeted victims, but may be physically injured or emotionally and developmentally damaged as a result of witnessing the spouse abuse or by being used by the perpetrator as pawns against the adult victim (see section V). In such families, both the adult intimate and the children are victims of the spouse abuse.
Abuse of the elderly is also not included in this definition of domestic violence unless it is perpetrated by the elder's intimate partner. Neither is abuse of parents by children nor sibling

violence included. While these types of family violence result in the same kind of physical injuries and some of the same psychological damage found in domestic violence cases, the dynamics are different, require different interventions, and are beyond the scope of this training.

Function of Domestic Violence: Pattern of Control

Domestic violence is purposeful and instrumental behavior. The perpetrator's pattern of abusive acts is directed at achieving compliance from or control over the victim. It is directed at circumscribing the life of the victim so that independent thought and action are curtailed and so that the victim will become devoted to fulfilling the needs and requirements of the perpetrator (Hart, 1991). The pattern is not impulsive or "out of control" behavior (see section II). Tactics that work to control the victim are selectively chosen by the perpetrator (Ganley, 1981; Serum, 1982; Pence and Paymar, 1993).

Pattern of Behaviors Used by Perpetrator

Domestic violence is not an isolated, individual event, but rather a pattern of repeated behaviors. Unlike stranger-to-stranger violence, in domestic violence the assaults are repeated against the same victim by the same perpetrator. These assaults occur in different forms: physical, sexual, psychological. The pattern may include economic control as well. While physical assault may occur infrequently, other parts of the pattern may occur daily. One battering episode builds on past episodes and sets the stage for future episodes. All tactics of the pattern interact with each other and have profound effects on the victims.

There is a wide range of coercive behaviors with a wide range of consequences, some physically injurious and some not; however, all are psychologically damaging. Some parts of the pattern are clearly chargeable as crimes in most states (e.g.. physical assault, sexual assault, menacing, arson, kidnapping, harassment), while other battering episodes are not illegal (e.g., name-calling, interrogating children, denying access to the family automobile, control of financial resources). While the family preservation practitioner may attempt to make sense of one incident that resulted in an injury, the victim is dealing with that one episode in the context of a pattern of both obvious and subtle episodes of coercion.

1. **PHYSICAL ASSAULT**

   Physical abuse includes spitting, scratching, biting, grabbing, shaking, shoving, pushing, restraining, throwing, twisting, slapping (open or closed hand),

   punching, choking, burning, and using weapons (household objects, knives, guns) against the victim. Some assaults result in physical injury and some do not. Sometimes a seemingly less serious type of physical abuse (e.g., a shove or push) can result in the most serious injury. The perpetrator may push the victim against a couch, a wall, down a flight of stairs, out of a moving car - all resulting in varying degrees of trauma.

2. **SEXUAL ASSAULT**

Like physical abuse, sexual battering includes a wide range of behaviors: from pressured sex when the victim does not want sex, to coerced sex by manipulation or threat of physical force, or violent sex. Victims may be coerced or forced into a kind of sex they do not want (e.g., sex with third parties, physically painful sex, sexual activity they find offensive) or at a time they do not want it (e.g., when exhausted, in front of children, after a physical assault, when they are asleep, when they are not interested). In pressured sex, the perpetrator's tactics are more subtle: sulking or complaining when the victim says no. Sometimes victims will resist and then are punished, and sometimes they comply in hopes that the sexual abuse will end quickly. For many battered women this sexual violation is profound and may be difficult to discuss. Some battered women may be unsure whether this sexual abuse is really abuse, while for others it is clearly the ultimate betrayal.

3. PSYCHOLOGICAL ASSAULT

There are several different uses of psychological assault. Because perpetrators will use various combinations of these tactics an individual victim will not necessarily have experienced all of them.

a. Threats of violence and physical harm

The perpetrator's threats of harm may be against the victim or others important to the victim, or they may be threats of suicide by the perpetrator. The threats may be made directly by words (e.g.,. "I'm going to kill you.," "No one is going to have you if I can't have you," "Your mother is going to pay," "I cannot live without you") or by actions (e.g., stalking, displaying of weapons, hostage-taking, suicide attempts). Sometimes the perpetrator coerces the victim into doing something illegal and then threatens to expose her, or he makes false accusations against her (e.g., reports her to CPS, welfare, Immigration).

b. Attacks against property or pets and other acts of intimidation

Attacks against property and pets are not random property destruction, but are part of the perpetrator's attempts to control the victim. It is the wall the victim is standing near that the perpetrator hits, or the door that she is hiding behind that gets torn off the hinges, or the victim's favorite china that is smashed or her pet cat that is strangled in front of her. It is the table that she

is sitting near that gets pounded or some favorite object of the perpetrator that gets smashed as he says,, "Look what you made me do." The covert message to the victim is always, "You can be next." The intimidation can also be carried out without damage to property (e.g., yelling and screaming in a person's face, standing over the victim during a fight, reckless driving when victim or children are present). These acts are carried out to instill fear in the victim.

c. Emotional abuse

Emotional abuse as a tactic of control consists of a variety of verbal attacks and humiliations and occurs in the context of the threat or existence of physical harm. Emotional abuse consists of repeated verbal attacks against the partner's sense of self as an individual, parent, family member, friend, worker, or community member. The verbal attacks are sometimes fabricated with particular sensitivity

to the victim's vulnerabilities (e.g., verbally abusing a victim about her history as an incest victim or about her language abilities, her skills as a parent, or her religious beliefs). Sometimes the perpetrator will undercut her sense of reality (e.g., specifically directing her to do one thing, and, when she complies, claiming that he never asked her to do it). Sometimes the emotional abuse consists of coercing her into doing very degrading things: ordering her to go to his mistress's home to retrieve her children, to get on her knees and use a toothbrush to clean up the food he smeared on the kitchen floor, or to violate her own moral standards. Sometimes the emotional abuse consists of humiliating her by verbally attacking her in front of family, friends, or strangers.

These tactics are similar to those used against prisoners of war or hostages and they are done for the same purpose: to gain and maintain the power and control of the perpetrator over the victim. When used by a perpetrator who is an intimate rather than a stranger or enemy, these tactics are even more confusing and ultimately more damaging.

The emotional abuse in domestic violence cases is not merely a matter of someone getting angry and calling his partner a few names or cursing. Not all verbal attacks or insults between intimates are necessarily acts of domestic violence. In order for a verbal insult to be considered domestic violence, it must be part of a pattern of coercive behaviors in which the perpetrator is using or threatening to use physical force. The verbal attacks and other tactics of control are intertwined with the threat of harm to maintain the perpetrator's dominance in the relationship through fear. While repeated verbal insults and abuse are damaging to both the partner and the relationship over time, they alone do not establish the same climate of fear as does verbal abuse combined with the threat of physical harm. Emotionally abusive relationships may be damaging, but they are not lethal. Therefore, interventions for relationships with no threat of violence do not always have to focus on the victim's safety.

Not all "bad" relationships are domestic violence cases: therefore careful identification and assessment interviews need to be carried out in less obvious cases. If the victim feels abused or controlled or afraid of her partner without clear descriptions of physical harm, then it is important to accept the client's view and to respond to concerns about her safety and psychological well-being.

d. Isolation

Perpetrators try to control victims' time, activities, and contact with others. They gain psychological control over victims by a combination of isolating and disinformation tactics Isolating tactics may become more overtly abusive as time passes At first, perpetrators cut off their victims from other supportive relationships by claims of loving them so much that they want to be with them all the time. In response to these statements, a victim initially spends ever-increasing amounts of time with the perpetrator. Subtle ways of isolating the victim are replaced with more overt means of verbal abuse (e.g., complaints about "interfering family" or "dykey" looking friends, or the victim's spending too much time with others). Sometimes the perpetrator uses physical assaults to separate the victim from family or friends. Through incremental isolation, the

perpetrator can increase his psychological control of the victim to such a degree that he seems to determine her reality.

In addition to the isolating tactics, there are disinformation tactics. These include distorting what is real through lies, contradictory information, or withholding information. For example, perpetrators may lie to victims about their legal rights or the outcomes of family preservation interventions Victims believe what perpetrators say because they are isolated from other sources of information. Consequently, it is crucial that victims be given accurate and complete information through several sources in order to refute the disinformation.

e. Use of children

Some of the abusive acts are directed against or involve the children, but in fact the perpetrator may be using these tactics to control or punish the adult victim (e.g., physical attacks against the children, sexual use of the children, forcing children to watch the abuse of the victim or engaging them in this abuse). Perpetrators use children to maintain control over their partners by requiring children to spy on the victim, requiring that at least one child always be in the victim's company, threatening to take children away, involving the victim in long legal fights over custody, or kidnapping children as a way to force the victim's compliance. Children are drawn into the assaults and sometimes are injured simply because they were present during the violent assault (e.g., the victim was holding infant when pushed against the wall) or because the child attempted to intervene. Visitations may be used by the perpetrator to monitor or control the victim.

These visitations become nightmares for the children as they are interrogated about the victim's daily life, sexually abused, or physically abused (see section V for additional

examples and discussion of impact on children). Children are used as one more tactic of control.

4. ECONOMIC CONTROL

Some perpetrators control victims by controlling their access to all of the family resources: time, transportation, food, clothing, shelter, and money. In some domestic violence cases it does not matter whether the victim or the perpetrator is the primary financial provider or whether both contribute; the perpetrator controls how the finances are spent. He may actively resist her becoming financially self-sufficient as a way to maintain his power and control over her. He may expect her to be the family "bookkeeper," with her keeping all records and writing all checks, or he may keep financial information away from her. In both scenarios, he alone makes the decisions about how resources are used. Victims are put in the position of having to get "permission" to spend money on basic family needs. When victims leave battering relationships. some perpetrators will use economics as a way to maintain control (e.g., instituting legal procedures costly to the victim, destroying assets in which she has a share, refusing to work "on the books" where there would be legal access to his income). All of these tactics may be used regardless of the economic class of the family.

B. Relationship Between Violence and Other Tactics of Control

It is perpetrators' use of physical and sexual force or threat to harm person or property that gives power to their psychologically abusive acts. Psychological battering becomes an effective weapon in controlling victims because they know through experience that perpetrators will at times back up the threats or taunts with physical assaults. Sometimes a perpetrator uses physical force infrequently or has only used it in the past. The physical assault may have happened only once or consisted of a shoving incident without injury. Perhaps the violence was against someone other than the victim (e.g., a previous intimate partner, in war, on the street). The reality that the perpetrator has used violence in the past against that victim or another to get what he wants gives the perpetrator additional power by establishing fear in the victim.

Perpetrators will use that fear to coercively control victims through other. non-physical tactics. Sometimes a perpetrator is able to gain compliance from the victim by simply saying, "Remember what happened the last time you tried to get a job?" referring to a time in the past when the perpetrator assaulted the victim. Because of that past use of physical force, there is an implied threat in the statement and the victim becomes reluctant to pursue a job against the perpetrator's singular wishes. Sometimes he will refer to his violence against others ("You know, I was a trained killer in the military" or "You're acting like Susie and you know what happened to her"). These may also be direct threats to kill or maim the victim or others. This threat of physical harm forms the foundation for all the other abusive acts.

Psychological control of the victim through intermittent use of physical assault along with psychological abuse is typical of domestic violence and is the same set of control tactics used against hostages or prisoners of war (Graham and Rawlings, 1991;. Ganley. 1981). Sometimes physical abuse, threats of harm, and isolation tactics are interwoven with seemingly loving gestures (e.g., sending flowers after an assault, making romantic promises, tearfully promising it will never happen again). The perpetrator is able to control the victim through this combination of physical and psychological tactics since the perpetrator connects the threat of physical harm so closely with the psychological tactics. The message is always there that if the victim does not respond to this "loving" gesture or verbal abuse then the perpetrator will escalate and use whichever tactic, including force, is necessary to get what he wants.

C. Are Both Partners Abusive?

Some mistakenly argue that often both the perpetrator and the victim are abusive: one physically and one verbally. It is the "it takes two to tango" theory. While some victims may resort to verbal insults, perpetrators use both physical and verbal assaults. Verbal aggression is not the same as a fist in the face. Research is contradictory about whether or not both perpetrators and victims are equally verbally aggressive. One study indicates that domestic violence perpetrators are more verbally abusive than either their victims, other persons in distressed/nonviolent relationships, or persons in non-distressed intimate relationships (Margolin et at., 1987). Another study found that both victims and perpetrators were verbally aggressive (Jacobsen, Gottman, Watty, Rushe, Babcock, Holtzman-Munroe, 1994). What

perpetrators report as abusive behavior by the victim are often acts of resistance by victims to abuse. Victims engage in strategies for survival during which they sometimes resist the demands of the perpetrators (see section III). Perpetrators respond with escalating tactics of control and violence.

Some argue that there is "mutual battering" when both individuals are using physical force against each other. In cases where two people are using force, we need to determine who may be primary aggressor and who may be the victim in order to intervene appropriately. This assessment should be based on descriptions of the event in question, but also on the history of prior violence and threats in the relationship. Careful assessment may reveal that one person is the primary physical aggressor while the victim's violence is in self-defense (e.g., she stabbed him as he was choking her), or occurred when the perpetrator's violence was more severe (e.g., his punching/choking versus her scratching) (Saunders, 1986). Sometimes the issue of who is the perpetrator and who is the victim can be clarified by asking which partner is terrified by the other's behavior.

E. Impact of Domestic Violence: Serious Injury and/or Death

Domestic violence can result in serious injury and/or death as well as in chronic health problems. Forty-two percent of murdered women are killed by their intimate partner[2].

[2]Analysis conducted by the Center for the Study and Prevention of Violence. institute for Behavioral Science. University of Colorado. The data used to calculate this percentage came from the FBI's 1988 & 1991 Uniform Crime Reports.

The lethality of domestic violence is tragically clear when the perpetrators kill their partners as well as children or other family members, then kill themselves. The lethality of the perpetrators' violence often increases when they believe that their victims have left or are about to leave the relationship (Campbell, 1992). Thus. some victims may be at greatest risk at the point when they attempt to escape the abuse by severing the relationship. For this reason, it is crucial that victims outline a safety plan during this dangerous period (see section III). The research indicates that while it is possible to accurately predict homicides, the most reliable predictor of future violence is the history of violence.

Typically, lethality assessment focuses on whether the perpetrator will severely injure or kill the victim, someone else or himself. Unfortunately, that is not the only way injury or death may occur. Sometimes the victim becomes suicidal, seeking a way out of an impossible situation. Sometimes the children may use force against others or themselves. In a desperate attempt to protect herself or her children, a victim may use physical force against the abuser. Research on battered women who kill clearly indicates there are no differences between the battered women who kill and those who do not. The only predictors of which women will resort to this means of protection rest in characteristics of their perpetrators (perpetrator's substance abuse, severity of violence) rather than in the women themselves (Browne. 1987).

Measuring the impact of domestic assaults in terms of permanent and health- shattering injuries and illness is another way to understand their lethal nature. For every homicide victim of domestic violence, there are multiple victims struggling with major health problems who did not die when shot, stabbed, clubbed, burned, choked, beaten, or thrown. And there are many

other victims whose problems are left unidentified or improperly treated as a result of being trapped in these relationships.

Without intervention, the overall pattern of domestic violence continues. While there is some evidence that physical assault decreases with age, there is no evidence that the perpetrator's abusive behavior simply stops on its own. Even with intervention many perpetrators will continue to be abusive. Moreover, there is evidence that over time damage to victims and children worsens (Stark, Flitcraft, and Frazier, 1979; M.A. Dutton, 1992; Jaffe, Wolfe, and Wilson, 1990; Peled, Jaffe, and Edelson, 1994.)

II. CAUSES OF DOMESTIC VIOLENCE

A. Domestic Violence is Learning-Based Behavior

Domestic violence is behavior learned through observation and reinforcement. It is not caused by genetics or illness (Bandura, 1973;. Dutton, 1988). Violent behaviors, as well as the rules and regulations of when, where, against whom, and by whom they are to be used, are

learned through observation (e.g., the male child witnessing abuse of his mother by his father or seeing images of violence against women in the media) or through experiences (e.g., perpetrators not held responsible, arrested, prosecutes or sentenced appropriately for abusiveness due to a culturally sanctioned belief that men are supposed to control their partners).

Domestic violence is observed and reinforced not only in the family, but in society. It gets overtly, covertly, and inadvertently reinforced by society's major institutions: familial, social, legal, religious, educational, mental health, medical, entertainment/media (Bandura, 1973; Dutton, 1988; Ganley, 1989). In these institutions, there are customs that facilitate the use of violence as legitimate means of controlling family members at certain times (e.g., religious institutions stating that a woman should submit to the will of her husband, laws that do not consider violence against intimates a crime, health systems that collude with the perpetrator by blaming victims for "provoking" the violence). These practices inadvertently reinforce the use of violence to control intimates by failing to hold the perpetrator responsible and by failing to protect the victim(s). (For a more complete listing see Dobash and Dobash, 1979.)

Domestic violence is repeated because it works. The pattern of domestic violence allows the perpetrator to gain control of the victim through fear and intimidation. Gaining the victim's compliance, even temporarily, reinforces the perpetrator's use of these tactics of control. But more importantly the perpetrator is able to reinforce his abusive behavior because of the socially sanctioned belief that men have the right to control women in relationships and the right to use force to ensure that control.

B. Domestic Violence Is Not Caused By Illness

A small percentage of violence against adult intimates is illness-based behavior rather than domestic violence. With informational assessments by community agencies, the violence may be incorrectly labeled domestic violence when it is actually caused by organic or psychotic impairments and is not part of a learned pattern of coercive control. Individuals with diseases such as Alzheimer's, Huntington's chorea, or psychosis may strike out at an intimate partner. Police are called, and in states that have mandatory arrest with probable cause, the case may be incorrectly identified as domestic violence. While it is true that the individual did use physical force against an adult partner, the physical violence may not be part of a pattern of coercive control.
Through a formal assessment, it is relatively easy to distinguish illness-based violence from learning-based violence. With illness-based violence, there is usually no selection of a

particular victim (whoever is present when the short circuit occurs will get attacked: e.g., health care provider, family member; friend, stranger). With learning-based violence, perpetrators use targeted violence with the intent to maintain control over a specific victim.

With illness-based violence, there is usually a constellation of clear symptoms that indicate a disease process. For example, with an organic brain disease there are changes in speech, gait, physical coordination, etc. With psychosis there may multiple symptoms of the psychotic process (e.g., "I attacked her because she is a CIA agent sent by the pope to spy on me using the TV monitor"). Poor recall of the event alone is not an indicator of illness-based violence (see section IV for discussion of perpetrator minimization and denial). When there is poor recall, future assessment is required to determine if there are other symptoms of a disease process. With illness-based violence the acts are strongly associated with the progression of a disease, (e.g., patient showed no prior acts of violence or abusive behavior in the 20-year marriage until other symptoms of the organic process appeared). With learning-based violence there is no indication of a disease process.

Sometimes assessment reveals that an individual may have an illness as well as a learned pattern of domestic violence, as in a case where an Alzheimer's patient had a history of domestic violence prior to the onset of the disease. Assessment of these multi-issue persons is necessary in planning the most appropriate intervention.

There has been no research to evaluate what percentage of cases identified as domestic violence may be illness-based. In a clinical sample at the Veteran's Administration Hospital in Seattle, WA, of those identified by community agencies (police and courts) as domestic violence cases, less than 5 percent turn out to be a result of an organic process. While more research is needed on this issue, in the vast majority of families where physical force is being used against intimate partners, the pattern of violence will be the result of the perpetrator's learning rather than an illness.

Knowing that there are cases where the violence against a partner is caused by disease does not alter the fact that violence has occurred, but it does alter the recommendations for intervention. The perpetrator of illness-based violence would not benefit from specialized domestic violence programs. Illness-based violence can be most effectively managed by appropriate medical or mental-health interventions and case management (e.g., instituting day treatment, appropriate medications, respite care, institutionalization when necessary).

C. Domestic Violence Is Not Caused By Alcohol or Most Other Drugs

Alcohol and other drugs such as marijuana, depressants, anti-depressants, or anti- anxiety drugs do not cause non-violent persons to become violent. Many people use or abuse those drugs without ever battering their partners. Research indicates that the pattern of coercive behaviors that comprise domestic violence is not caused by those particular chemicals (Critchlow, 1986), although alcohol and other drugs may be used as an excuse for the battering. On the other hand, there seems to be contradictory evidence whether certain drugs (PCP, speed, cocaine or its derivative, "crack") chemically react within the brain to cause violent behavior or whether they induce paranoia or psychosis, which is then accompanied by violent behavior. Further research is needed to explore the cause-and-effect relationship between those drugs and violence.

Some people who consume these drugs are violent with or without the chemical in their bodies. An addict's violence may be part of a lifestyle wherein everything, including family life, is orchestrated around the acquisition and consumption of drugs. Other addicts are so focused on their addiction that they withdraw from relationships and do not engage in any controlling behavior toward family members.

Research studies have found a high correlation between aggression and the consumption of various substances, but there is no data proving a cause-and-effect relationship. Clinicians point to those substance abusers who become less abusive or controlling toward partners rather than more so as evidence that there is not a simple cause and effect between the chemical and violent behavior.

There have been a variety of explanations for the high correlation. Some say that alcohol and drugs provide a disinhibiting effect wherein individuals have permission to do things that they otherwise would not do. Others point to the increased irritability or hostility of the user which may lead to violence.

While research is not definitive, clinical experience cautions against viewing domestic violence as primarily caused by alcoholism or drug addiction. Such a view can misdirect interventions to the substance abuse rather than to the domestic violence. For those who are addicted to alcohol and drugs, stopping violent behavior is difficult without also stopping substance abuse. However, it is not sufficient to treat the chemically affected perpetrator solely for either substance abuse or domestic violence. Intervention must be directed at both problems either through (a) concurrent interventions; (b) inpatient substance-abuse treatment with a mandatory follow-up program for domestic violence; or (c) an involuntary mental-health commitment with rehabilitation directed at both the addiction and the violence.

While the presence of alcohol or drugs should not be considered an excuse for violence, it is relevant to the assessment of lethality and safety planning. The use of, or addiction to, substances may increase the lethality of certain episodes of domestic violence and needs to be carefully considered when addressing safety issues (Browne, 1987).

D. Domestic Violence Is Not "Out of Control" Behavior

Perpetrators follow their own internal rules and regulations about their abusive behaviors. Some will batter only in particular ways, hitting certain parts of the body, while others will use violence toward the victim even though they may be in conflict with their boss, other family members, or the family preservation practitioner. Some will hit only in private while others will strike the victim in public; some will break only the victim's possessions and not their own;

and others will not engage in any property destruction. The patterns vary from abuser to abuser. Perpetrators are making choices about what they will or will not do to the victim, even when they are claiming that they "lost it" or were "out of control." Such decision-making indicates they are actually in control of their abusive behaviors (Ganley. 1981; Adams. 1988).

E. Domestic Violence Is Not Caused By Stress

There are many different sources of stress in our lives (e.g., stress from the job, stress from not having a job, marital and relationship conflicts, illness, death, discrimination, poverty, racism), and people respond to stress in a wide variety of ways, including problem-solving, substance abuse, eating, laughing, withdrawal, and violence (Bandura. 1973). Stress does not "cause" people to act in certain ways. They react to the stresses of their lives in ways

They have observed as working in the past or anticipate will work in the present. Furthermore, a stress-reduction theory of violence does not explain why individuals stressed by employment, racism, or illness direct their violence at their intimate partners rather than the sources of their stress. Moreover, many episodes of domestic violence occur when the perpetrator is not emotionally charged or stressed.

It is important to hold people responsible for the choices they make regarding stress reduction, especially when those chooses involve violence or other illegal behaviors, just as we would not excuse a robbery or a mugging by a stranger simply because the perpetrator was stressed. We can no longer excuse the perpetrator of domestic violence because of stress.

F. Domestic Violence Is Not Caused By Anger

When evaluating the role of anger in domestic violence, one must consider its role as part of a pattern and not just in isolated, individual events. There is a great deal of variability within one perpetrator's pattern as well as between perpetrators. Some battering episodes occur when the perpetrator is not emotionally charged or angry, and some occur when the perpetrator is very emotionally aroused. In some episodes, he uses the tactics of control calmly, while in others displays of anger are often tactics to intimidate the victim. Expressions of anger can be quickly altered when the abuser thinks it is necessary. Perpetrators choose to use violence or other tactics of control such as displays of anger to get what they want or that to which they feel entitled.
Current research indicates that there is a wide variety of arousal or anger patterns among identified perpetrators as well as among those who are identified as not abusive (Gottman et al., 1995; Jacobson et al., 1994). These studies suggest that there may be different types of batterers. Abusers in one cluster actually reduced their heart rates during observed in-marital conflicts, suggesting a calm preparation for fighting rather than an out-of-control or angry response. Such research challenges the notion that domestic violence is merely an anger problem and raises questions about the efficacy of anger-management programs for batterers.

G. Domestic Violence Is Not Caused By The Victim's Behavior or By Relationship Problems

Looking at the relationship or the victim's behavior as an explanation for domestic violence takes the focus off the perpetrator's responsibility, and unintentionally supports his minimization, denials, blaming, and rationalizations of violent behavior. This inadvertently

reinforces the perpetrator's abuse and thus contributes to the escalation of the pattern of domestic violence. People can be in distressed relationships and experience negative feelings about the other's behavior without being forced to respond with violence or other criminal activities. While some victims may have problems (e.g., substance abuse, poor communication skills, parenting difficulties), violence is not a reasonable, or a legal, response.

Many perpetrators repeat their pattern of control in all their intimate relationships, regardless of significant differences in the personalities of their intimate partners or in the characteristics of those relationships. This further supports the position that while domestic violence takes place within a relationship, it is not caused by the relationship.

Domestic violence in adolescent relationships illustrates further that abuse is not the result of a victim's behavior. Often the adolescent abuser only superficially knows his victim, having dated only a few days or weeks before the abuse begins. Such an abuser is acting out an image of how to conduct an intimate relationship based on recommendations of his peers, music videos, or models set by family members.

Adult and adolescent perpetrators bring into their intimate relationships certain expectations of who is in charge and what the acceptable mechanisms are for enforcing that dominance. Those attitudes and beliefs. rather than the victims' behavior, determine whether or not perpetrators are domestically violent.

H. Domestic Violence Is A Socially-Constructed, Gender-Specific Behavior

Male violence against women in intimate relationships is a social problem condoned and supported by the customs and traditions of a particular society. The majority of perpetrators in domestic violence cases are male, while the majority of victims are female. (Dobash et al., 1992), even though male-to-male, female-to-female, and female-to-male violence does occur in intimate relationships (Hamberger and Potente, 1994; Renzette, 1994).

The U.S. Department of Justice estimates that 95 percent of assaults on spouses or ex-spouses are committed by men against women (Douglas, 1991).

While heterosexual women sometimes use physical force against partners, it is often self-defensive violence (Saunders, 1986). Furthermore, studies indicate that while both men and women sometimes use some of the same behaviors, the effects of male violence are far more serious than female aggression as measured by the frequency and severity of injuries (Berk et al., 1983; Jacobson et al., 1994). Male perpetrators of homicide are more likely to stalk the victim, kill the victim and/or other family members, and/or commit suicide than are female perpetrators (Wilson and Daley, 1992). Women are unlikely to commit homicide except in self-defense (Wilson and Daley, 1992). Although there is a gender pattern to domestic violence that must be understood to develop long- term prevention programs, the community must take the problem seriously regardless of who is doing it to whom.

III. THE VICTIM OF DOMESTIC VIOLENCE

A. Victims of Domestic Violence Can Be Found in All Age, Racial, Socioeconomic, Educational, Occupational, Religious, and Personality Groups

Victims of domestic violence are a very heterogeneous population whose primary commonality is that they are being abused by someone with whom they are, or have been, intimate. They do not fit into any specific age cohort, racial group or personality profile.

Too often, victimization is seen as a problem for one group and not another. For example, in talking about domestic violence, teen victims are often overlooked. With further documentation of dating violence (Levy, 1), there is a call for more attention to this issue by professionals in contact with adolescents just beginning to have intimate relationships. All age groups have the potential to be victimized by a perpetrator of domestic violence. Sometimes ignoring domestic violence takes another form, such as racial stereotypes which communicate that wife-beating is just a way of life or "culturally acceptable" in "that" group. There is little comprehensive research on prevalence and acceptability of domestic violence in various racial or ethnic groups (Hampton, 1987). What research has been done raises more questions than answers, partly because the studies use varying definitions of domestic violence with differing results (Campbell, 1992; Erchak and Rosenfeld, 1994; Straus and Gelles, 1990). What some literature does show is that rather than ignoring domestic violence in various cultures, the community needs to respond to it by developing interventions that are culturally specific (Agtuca, 1992; Zambrano, 1985; Kim, et. al, 1991; White, 1985; Family Violence Prevention Fund, et. al, 1991).

Early studies (Snell, Rosenwald, and Robey, 1964) on victims of domestic violence attempted to focus on characteristics of the victim that would provide a causative explanation for the violence. Later studies indicate that no causative explanation has been found between characteristics of victims and their victimization (Hotaling and Sugarman, 1986). Domestic violence is the result of the abuser's behaviors rather than personal characteristics of the victim. Consequently, just as with victims of other trauma (e.g., car accidents, floods, muggings), there is no particular type of person who is battered.

B. Victims May or May Not Have Been Abused as- Children, Or In Previous Relationships

Just as some people looked to personality or demographic characteristics of the victim to explain their victimization, it has been suggested that domestic violence victims have been victims of childhood abuse and/or of previous violent relationships, and that somehow this previous victimization contributed to their current situation. Yet there is no evidence that previous victimization either as adults or as children results in women seeking out or causing current victimization (Walker, 1984). Some victims of domestic violence have been victimized in the past and some have not. While it may be helpful to an individual victim to understand her history of victimization and her coping mechanisms in dealing with past and current abuse, it is not helpful to make inaccurate victim-blaming interpretations of this history.

C. Some Victims Become Very Isolated As A Result of the Perpetrator's Control Over Their Activities, Friends, Contacts with Family Members, Etc.

Some of the victim's behaviors when interacting with the family preservation practitioner (e.g., her reluctance to commit to a particular intervention plan that requires multiple

appointments, her lack of confidence in her own abilities, her fear of the perpetrator) can be understood in light of the control the perpetrator has managed to enforce through isolating the victim. Without outside contact and information, it becomes more difficult for the victim to avoid the perpetrator's psychological control. Some victims come to believe the perpetrator when they are told that if they leave, they will not be able to survive alone; others resist such distortions.

Even when the victim maintains contact with friends or extended family, often those relationships are mediated through the perpetrator's control and the victim does not experience the support and advocacy she needs. The perpetrator may interrogate the victim about every detail of her interactions with other people and repeatedly make negative remarks about these interactions. Positive feedback or support from these relationships is often undermined by the perpetrator's intrusions on them.

D. Some Victims Repeatedly Stay, Leave, or Return To Abusive Relationships

One of the most commonly asked questions about domestic violence is why victims stay in violent relationships. The reality is that many victims do not stay and many others come and go (Dobash and Dobash, 1979). Leaving a violent relationship is a process that takes place over time.

The primary reason given by victims for staying with their abusers is fear of violence and the lack of real options to be safe with their children. This fear of violence is realistic. Research shows that domestic violence tends to escalate when victims leave their relationship (Campbell, 1992.; Gillespie, 1989).

Some perpetrators repeatedly threaten to kill or seriously injure their victims should they attempt to leave the relationship. The victim may have already attempted to leave in the past, only to be tracked down by the perpetrator and seriously injured. Many perpetrators do not let victims simply leave relationships. They will use violence and other tactics of control to maintain the relationship. It is a myth that victims stay with perpetrators because they like to be abused. Even in cases where the victims were abused as children, they do not seek out violence nor do they wish to be battered.

There are many reasons for staying in a violent relationship, and they vary for each victim. They may include:

- fear of violence and the perpetrator
- lack of shelters and victim-advocacy programs to provide transitional support

- lack of affordable housing that would provide safety for the victim and children
- lack of real alternatives for employment and financial assistance, especially for victims with children
- lack of affordable legal assistance necessary to obtain a divorce, custody order, or a restraining order or protection order
- being immobilized by psychological and physical trauma (victims of trauma may not be able to mobilize all that it takes to separate and establish a new life for themselves and their children, particularly during the period immediately following the trauma or if they have suffered multiple traumas)
- believing in cultural/family/religious values that encourage the maintenance of the family unit at all costs
- continuing to hope and believe the perpetrator's promises to change and to stop being violent because of the perpetrator's positive qualities
- being told by the perpetrator, counselors, the courts, police, ministers, family members, and friends that the violence is the victim's fault, and that she could stop the abuse simply by complying with the perpetrator's demands; in these cases, the victim learns that the systems with the power to intervene will not act, and she is forced to comply with the perpetrator in hopes of stopping the abuse

E. Domestic Violence Victims Employ Many Survival Strategies

What at first may appear to the family preservation practitioner to be "crazy" or inappropriate behavior on the part of the victim (e.g., being too fearful to ask her partner to use safe-sex precautions, being afraid to use legal remedies or seek battered women's advocacy services, or wanting to return to the perpetrator in spite of severe violence) may in fact be normal reactions to a "crazy" and very frightening situation (M.A. Dutton, 1992).

A victim uses many different strategies to cope with and resist abuse. Such strategies include: agreeing with the perpetrator's denial and minimization of the violence in public, accepting the perpetrator's promises that it will never happen again, saying that she "still loves him," being unwilling to terminate the relationship, and doing what he asks. These strategies may appear to be the result of passivity or submission, when in reality she has learned that these are sometimes successful temporary means of stopping the violence.
Many victims who appear reluctant to carry out actions that the family preservation practitioner believes would protect them and their children from further violence actually have the same goal as the practitioner: namely, to stop the violence. The victims simply have different strategies than the practitioner.

Sometimes the victim will begin to terminate the relationship by seeking assistance from the court system or social-service agencies, only to see that those systems are not effective in stopping the violence. For example, a protective order may not deter the perpetrator in communities where the police refuse to enforce the order. Where outside protection fails, the victim is forced to rely on strategies that she perceives to have worked in the past.

Because of these unsuccessful attempts at seeking outside assistance, the victim may be reluctant to assume that her safety and confidentiality will be respected by a family preservation practitioner. In such cases, unless the family preservation practitioner initiates the topic the victim may not even raise the issue. Other victims will readily name but minimize the abuse as a way to cope until they determine whether there really are the community supports necessary for protection. In such cases, the victim may re-engage the prior survival strategies of complying with the perpetrator.

Successful interventions must be based on an understanding of the victim's behavior as a normal response to violence perpetrated by an intimate. Rather than viewing them as masochistic, passive, crazy or inappropriate, or as an indication that the violence did not "really" occur, they should be viewed as survival strategies that may contribute to the victim's safety and the safety of her children.

IV. THE PERPETRATOR OF DOMESTIC VIOLENCE

There is no simple, predictive profile that can be used to determine whether or not someone is a perpetrator of domestic violence. Perpetrators are identified only by gathering information about their behavior. However, there are some common characteristics of perpetrators that are helpful to understand for identification, assessment, and intervention.

A. Perpetrators of Domestic Violence Can Be Found In All Age, Racial, Socioeconomic, Educational, Occupational and Religious Groups

Except for gender, as previously discussed, perpetrators seem to be a very heterogeneous population whose primary commonality is their use of violence. They do not fit into any specific personality category or other grouping.

In recent years, there has been growing interest in studying characteristics of perpetrators, especially to determine who may or may not benefit from rehabilitation programs (Gondolf, 1988; Tolman and Bennett, 1990; Saunders, 1992, 1993; O'Leary, Virian, and Malone, 1992; Hamberger and Hastings, 1988;. Dutton, 1988). Much of the research looks at specific samples: those issued protection orders by a model court project (Isaac et al., 1994) or those

in court-ordered treatment programs (Hamberger, 1988) While some differences are emerging, it is difficult to assess whether they are due to the sampling methods or are significant variables for understanding who the perpetrators are. The research is preliminary and therefore inconclusive, but it does indicate there is a great deal of diversity among perpetrators.

Sometimes a family preservation program or community agency will deal with one group more than another (e.g., a particular socioeconomic class or race). This experience with a limited sample of perpetrators may lead to some inaccurate generalizations about perpetrators (or victims).

Certain racial groups in the United States are sometimes viewed as being more violent than others, despite a lack of systematic study of this issue (Hawkins, 1986; Straus and Gelles, 1990).

The question of cultural differences among perpetrators is often raised regarding cases that involve persons of color or Third World Immigrants. In reality, most cultures, including white in the United States, have until recently been unwilling to take a stand against domestic violence. Without careful research, it is premature to say whether some racial groups perpetrate more domestic violence than others.

Perpetrators use various cultural justifications for their conduct, whether they are white North Americans or are from other ethnic or cultural groups. It is important not to become lost in those rationalizations In addition, both victims and perpetrators have varying expectations and experiences with interventions (Williams, 1994) depending on their cultural identity. While it is important to be sensitive to those cultural issues in designing interventions, it is also important to avoid letting cultural variations become a justification for the perpetrator's violence.

B. Domestic Violence Perpetrators Avoid Taking Responsibility for Their Conduct By Minimizing, Denying, Lying About or Justifying Their Abusive Tactics

Perpetrators minimize their abusive conduct or its impact on the victim and others by making the abuse appear less frequent and less severe than it really is. "I only hit her once," "I just pushed her to the floor," "The children never saw the abuse," "She bruises easily," "I'm not one of those wife-beaters. I have never punched her." In talking to others about the problem they will often use euphemisms for their violence - -"We're not getting along so well," "We had a little fight last night" - to describe incidents in which the victim required serious medical attention.

Sometimes perpetrators acknowledge what they do, but justify it by blaming the victim or something other than themselves. They externalize responsibility for their behavior to others or blame it on factors supposedly outside of their control. Perpetrators primarily blame the victims for the abuse: "She wouldn't listen to me," "She's an alcoholic," "She's crazy," "I can't handle her," "My wife is the abuser," "This pregnancy has made her wild," "She's suffering from postpartum depression," "She's clumsy," "She never pays attention to me."
Sometimes they blame other factors: "I have PTSD (post-traumatic stress disorder)/hypoglycemia/attention-deficit disorder/mood swings/alcoholism," "The social worker didn't like me and got his facts wrong," "The Child Protective Services worker believes anything my kids say," "I got one of those women's lib cops who wouldn't listen to my side."
Sometimes they do not lie about their behavior because they believe they have the right to do what they do. In blaming the victims or others; these perpetrators fail to mention their own violent and abusive behavior and avoid taking responsibility for it.

Sometimes perpetrators lie about their abuse to avoid the external consequences of their behavior and to maintain control of their partners. They will lie to victims, family, friends, police, judges, and anyone who has contact with them. They lie because they do not want to deal with the consequences (e.g., arrests, prosecution, jail, loss of visitation rights, loss of custody).

Sometimes perpetrators use denial and minimization not only to avoid external consequences, but also to protect themselves from the personal discomfort of recognizing they are abusing those they supposedly love. This denial is a means of deceiving themselves rather than others, just as there are alcoholics who are in denial about their drinking. There are perpetrators in

denial about their battering. The culture gives mixed messages about the acceptability of domestic violence. Some perpetrators do not like or accept what they are doing, so they distort it to make it more acceptable to themselves.

Regardless of why a perpetrator is distorting the truth, this distortion presents obstacles to assessment of and intervention with perpetrators. If perpetrators lie to others about the abuse, they will not put effort into changing their behavior. If they are in denial, they will not change a problem they do not think they have. Family preservation practitioners should be aware of these responses when talking with perpetrators directly. Collusion with the perpetrator by the family preservation practitioner will only increase the perpetrator's minimization and denial.

C. Some Domestic Violence Perpetrators Control the Victim Through the Family Preservation Program

The perpetrator uses multiple tactics of control against the victim. Sometimes he also enlists others in that control, either through misinformation or through intimidation directed toward them. These tactics are employed to coerce the victim to stop talking about the abuse to the practitioner, to get the victim to reunite with the perpetrator, to drop her objections to joint custody, or to do whatever else the perpetrator wants.

The following are examples of controlling behavior that the family preservation practitioner may witness:

- physical assaults or threats of violence against the victim or the family preservation practitioner, threats of suicide, threats to take the children, harassment
- stalking the victim to and from appointments or work
- accompanying the victim to all appointments; sending the victim "looks" during sessions, refusing to let the victim be interviewed separately
- bringing along family or friends to intimidate the victim or the family preservation practitioner
- making long speeches to the practitioner about all the victim's behaviors that made the perpetrator act violently
- crying and other displays of emotion or statements of profound devotion or remorse to the victim, alternated with threats or psychological abuse
- not following through with his responsibilities to the family preservation program or to other programs
- canceling the victim's appointments with the family preservation practitioner or sabotaging her efforts to attend appointments by not providing childcare or transportation
- denying the victim access to records that may support her position, or attempting to control her records

- using the legal system against the victim by requesting mutual orders of protection, making false charges of harassment/abuse against the victim, prolonging divorce proceedings; and a variety of other abuses of the system

- continually testing limits of visitation/support agreements (e.g., arriving late or not showing up at appointed times)

- threatening and/or implementing custody fights

- using any evidence of damage resulting from the abuse as evidence that the victim is an unfit parent (e.g., victim's counseling records, victim's treatment for depression or other medical conditions)

Sometimes in his attempts to control the victim, the perpetrator will attempt to control the family preservation practitioner with the same tactics of power and control used against the victim.

Examples include:

- intimidating the practitioner with a variety of threats or acts

- portraying himself as the good client and constantly praising the family preservation practitioner

- harassing the practitioner by false reports to superiors (e.g., alleging breaches of confidentiality, inappropriate treatment, rude behavior) and threats of legal action

- splitting family preservation teams by creating divisiveness among professionals (e.g., alleging one practitioner doesn't like the perpetrator and takes the victim's side)

D. The Perpetrators Control Also Extends To The Children As Well.

Perpetrators tend to be highly controlling of children (see section V). Some perpetrators think of their children merely as extensions of themselves and are often unable to separate their needs or issues as adults from the needs and issues of their children. For example, a perpetrator may insist that his child's visitation schedule meet the perpetrator's emotional needs rather than the best interests of the child. Domestic violence perpetrators are often unwilling or unable to consider the best interests of the child(ren).

E. Domestic Violence Perpetrators Act Excessively Jealous and Possessive In Order To Isolate Their Victims

The perpetrator may be very possessive of the victim's time and attention. He may often accuse the victim of sexual infidelity and other supposed infidelities, such as spending too much time with the children, the extended family and friends or at work. His jealousy is usually one more tactic in a pattern of coercive control. The perpetrator isolates the victim, interrupting

social/support networks by claiming jealousy. This isolation serves the perpetrator by preventing discovery of the abuse and by preventing others from holding him responsible.

F. Domestic Violence Perpetrators May Have Good Qualities In Addition To Their Abusive Conduct

Some domestic violence perpetrators may be good ,hard workers, good conversationalists, witty, charming, and intelligent yet they may still batter their victims. Sometimes the family preservation practitioner as well as the victim are misled by these positive qualities. They assume that the violence did not really happen or is an aberration, since only "monsters" could commit such acts - a "good" person would most certainly stop the abuse. But even seemingly normal and nice people may batter and may be very dangerous. Battering stops only when perpetrators are held responsible both for their abuse and for making the changes necessary to stop the violence. Battering stops when perpetrators choose to stop.

V. THE CHILDREN

Children living with domestic violence in the home are often the forgotten victims of domestic violence.

A. Overlap Between Domestic Violence and Child Abuse

Researchers estimate that the extent of overlap between domestic violence and child physical or sexual abuse ranges from 30 to 50 percent (Jaffe, Wolfe, and Wilson, 1990; Straus and Gelles, 1990). Pescott and Letko report 43 percent of women in a shelter had children who were victims of abuse by the domestic violence perpetrator. Roy reports 45 percent of the children of battered women are physically abused (both studies in Roy, 1977). Girls are 5 to 6 times more likely to be sexually abused by domestically violent fathers than by non-battering fathers (Bowker, Arbetel, and McFerron,. 1988). Some shelters report that the first reason many battered women give for fleeing the home is that the perpetrator was also attacking the children (New Beginnings, 1990). Victims report multiple concerns about the effects of spousal abuse on children (Hilton, 1992).

B. Perpetrators Traumatize Children In The Process of Battering Their Adult Intimate

Perpetrators of domestic violence traumatize and terrorize children in four ways:

- intentionally injuring the children as a way of threatening and controlling the abused parent (e.g., the child is used as a weapon against the victim, thrown at the victim or abused as a way to coerce the victim to do certain things)

- unintentionally injuring the children during an attack on the abused parent when the child gets caught in the fray, or when the child attempts to intervene (e.g., infant injured

when mother is thrown while holding the infant; a small child is injured when trying to stop the perpetrator's attack against the victim)

- creating an environment where children witness the abuse itself or its effects - research reveals that children who witness domestic violence are affected in the same way as children who are physically and sexually abused (Goodman and Rosenberg, 1987); in spite of what perpetrators or victims say, children have often either directly witnessed physical and psychological assaults or have indirectly witnessed them by overhearing episodes or by seeing the aftermath of the injuries and property damage

- using children to coercively control the abused parent either while living with or separated from the victim, with intent to continue the control over the adult victim, with little regard for the damage to the children (Walker and Edwall, 1987)

- Examples of the perpetrator's behavior that traumatizes and terrorizes children include but are not limited to:

- asserting that the children's "bad" behavior is the reason for the assault on the adult partner

- isolating the children along with the abused parent (e.g., not allowing the children to enter peer activities or friendships)
- engaging the children in the abuse of the other parent (e.g., making the children participate in physical, emotional, or sexual assaults against the adult)

- forcing children to watch the violence

- taking a child away after each violent episode to ensure that the adult victim will not flee the perpetrator

- holding the children hostage or abducting them in an effort to punish the victim or to gain her compliance

- engaging in long tirades aimed at the children about the abused parent's behaviors that caused the separation

- demanding unlimited visitation or access by telephone (e.g., insisting that adolescent sons stay alternate nights with the perpetrator after the separation, ignoring the children's needs for time with each other or with their friends)

C. Domestic Violence Can Physically, Emotionally and Cognitively Damage Children

Current research indicates that domestic violence affects children in a variety of ways, and that the effects are both short and long term (Jaffe, Wolfe. and Wilson, 1990). Children may be physically, emotionally, and cognitively damaged as a result of domestic violence. The nature and extent of the damage will vary depending primarily on three factors:

- the type and history of abusive control used by the perpetrator

- the age, gender, and developmental stage of the child
- situational factors, such as other social supports

Consequences of the perpetrator's abuse vary according to the age and developmental stage of the child (Jaffe, Wolfe, and Wilson, 1990). During infancy, the crucial developmental task is developing emotional attachments to others. Being able to make attachments provides a foundation for healthy development. Domestic violence not only interrupts the infant's attachment to the perpetrator, but can also interrupt the child's attachment to the mother. The perpetrator may directly interfere with the victim's care of the young child. The violence may not permit bonding between the child and either parent. This results in the child having difficulty in forming future relationships, and blocks the development of other age-appropriate skills and abilities.

The primary developmental tasks of children between the ages of 5 and 10 are role development and cognitive development. The perpetrator's violence and pattern of control impedes or derails both of these tasks. For example, a child may have difficulty learning basic concepts in school because of his or her anxieties about what is happening at home.
The central developmental task of teenagers is autonomy. This occurs partly as teens separate from parents and establish peer relationships. Often, what is learned in family relationships is replicated in peer relationships. Consequently, for teens who are coping with the perpetrator's abuse against the other parent, there is no positive role model for learning the skills necessary for establishing mutuality in healthy adult relationships (e.g., listening, support, non-violent problem-solving, compromise). The teenager will sometimes side with the abusive parent, viewing that parent as the one who is most powerful.

The negative effects of the perpetrator's abuse in interrupting childhood development can be seen immediately in cognitive, psychological, and physical symptoms (Jaffe, et. al., 1990) such as:

- fear
- eating/sleeping disorders
- mood-related disorders such as depression and emotional neediness
- overcompliance/clinginess/withdrawal aggressive acting-out/destructive rages
- detachment/avoidance/a fantasy family life
- somatic complaints
- finger biting/restlessness/shaking/stuttering
- school problems
- suicidal ideation

Children's experience of domestic violence also results in changes in perceptions and problem-solving ability, such as incorrectly seeing themselves as the cause of the perpetrator's violence against the intimate partner, or using either passive behaviors (e.g., withdrawal, compliance) or aggressive behaviors (e.g., verbal and/or physical striking-out) rather than assertive problem-solving skills.

There are also long-term effects as these children become adults. Since important developmental tasks are interrupted, they carry these deficits into adulthood. They may never catch up in certain academic tasks or in interpersonal skills. These deficits affect their abilities to maintain jobs and relationships. Male children in particular are affected and are at greater risk of battering intimates in their adult relationships (Hotaling and Sugarman, 1986). And sometimes the children do not wait to become adults before using violence themselves (e.g., against the victim, the perpetrator, their peers, other adults).

However, many children are not harmed irreparably by experiencing domestic violence in their families. A caring, supportive network can lessen the negative effects to the child and children can rebuild their sense of self as caring, competent beings. Once they are safe, they can return to normal developmental tasks.

D. The Most Effective Way To Protect The Children May Be To Protect The Non-Abusing Parent

In the face of overwhelming odds, victims of domestic violence do many things to protect their children from the perpetrator (e.g., intervening in the perpetrator's violence directed at the children, sending the children to others when they are-in danger, teaching the children safety plans, reminding the children that they are not responsible for the domestic violence, being very loving and engaged with the children). Sometimes the victim appears to be acting in ways that do not effectively protect the children from the perpetrator's violence because they are relatively powerless to do so.

One of the goals of intervention for victims with children is for victims to get the support and advocacy necessary to effectively protect their children. Often, the most effective way for the family preservation practitioner to protect the children is to protect and support the non-abusing parent. Removing that child from the care of a loving parent who is being abused herself is not the answer. Nor is putting the child into a treatment program without also ensuring that he/she has a safe home. Holding the perpetrator, not the victim, responsible for the abuse and protecting the abused parent from further violence is critical in protecting both the victim and the children.

V. THE COMMUNITY

Domestic violence ripples out into the community as the perpetrator's violence also results in the death or injury of those attempting to assist the victim, or of innocent bystanders. Examples of the tragic consequences of domestic violence to the community can be seen on a daily basis in newspapers across the country as they recount the latest homicide of an ex-spouse, current partner, the victim's children, innocent bystanders, and those who attempt to intervene. Although rarely identified by the media as "domestic violence" homicides, these cases almost

always have a history of abusive and controlling behavior by the perpetrator against the adult intimate.

- In California, a domestic violence perpetrator kills the victim, his daughters, and several of the victim's co-workers, as well as a police officer

- In New York, a nightclub is burned down by the boyfriend of an employee, resulting in numerous deaths of patrons inside

- In Colorado, a lawyer is shot in court by a domestic violence defendant

- In Washington, a lawyer is killed by the husband of a client he was defending in a custody case where domestic violence was alleged

- In Washington, a battered woman, her unborn child, two women friends are shot and killed in Superior court by the husband before closing arguments in an annulment hearing

The financial cost of domestic violence to the community in terms of medical care, absenteeism, and the response of the justice system is phenomenal. The cost in lost lives and resources is a constant reminder that domestic violence is not a family affair, nor is it merely a private affair. Domestic violence is a community affair demanding a community response.

VII. GUIDING PRINCIPLES AND APPLICATIONS FOR PRACTICE

Domestic violence cases present unique challenges for family preservation practitioners. Intervention in these cases must be based on a thorough understanding of both domestic violence and the role of the societal and familial contexts in reinforcing it. Stopping domestic violence requires a change in how practitioners work with individual families and requires coordination and collaboration with many parts of the community (e.g., child welfare, domestic violence programs, court systems). No one part of a community can do it alone. To be effective, a coordinated community response must share not only a common understanding of domestic violence, but also a common philosophy for responding to it.

A. Three Guiding Principles

There are three principles that provide the foundation of an effective community response to domestic violence. These principles are the outgrowth of our understanding of the nature and etiology of domestic violence. Taken as a group they provide a standard against which current and future policies, procedures, and practices can be evaluated. These guiding principles are as follows:

1. to increase the victim's and children's safety

2. to respect the authority and autonomy of the adult victim to direct her own life

3. to hold the perpetrator, not the victim, responsible for his abusive behavior and for stopping his abuse

This material was excepted from the manual entitled:
Domestic Violence: A National Curriculum for Family Preservation Practitioners,
produced by the Family Violence Prevention Fund.
Written by Susan Schechter and Anne L. Ganley, Ph. D., 1995.
Understanding Domestic Violence:
PREPARATORY READING FOR PARTICIPANTS
Chapter written by Anne L. Ganley, Ph.D.