
Male Partner Violence Against Women with Cognitive Disabilities

General Guidance for Community Outreach Workers

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**CATHOLIC
SOCIAL
SERVICES**

Sign of
Hope!



**UNIVERSITY OF
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- Women with cognitive disabilities experience male partner violence at a higher rate than non-disabled women. They also tend to remain in abusive relationships for longer, due in part to their social isolation and a lack of appropriately adapted services. Many survivors suffer post-traumatic stress and or stress-related health conditions long after the violence has stopped. This Guide, which is based on a review of literature and interviews with five experienced practitioners, offers some general guidance for community outreach workers supporting women with cognitive disabilities after the initial crisis of ending an abusive relationship.
- Attentive to each woman's individual needs, priorities and preferences, and working within their scope of practice and in concert with other service providers as appropriate, community outreach workers can assist women with cognitive disabilities with a range of challenges and tasks including safety planning, navigating systems (e.g., informing, screening, referring), securing basic resources (e.g., healthcare, housing, income, childcare, transport), capacity or skill-building (e.g., symptom management, safety awareness, self-advocacy), developing a social support network, and meaning-work.



PRACTICE POINT 1. Individualized, context-sensitive assessment and support

Few generalizations can be made about the capacity or support needs of women with cognitive disabilities (CD). Any woman with CD may demonstrate capacity in one context but struggle to do so in another depending, for example, on her level of stress or fatigue. The implication is that support should be tailored to each woman's individual strengths, needs and life situation.

DEFINITIONS

Cognitive disabilities (CD), as used here, is an umbrella term covering intellectual disability and cognitive impairments associated with fetal alcohol exposure and acquired brain injury. The majority of women with CD have mild intellectual disability, characterized by significant limitations in intellectual functioning (e.g., learning, planning, problem-solving) and adaptive behavior, originating in childhood. It is important to understand that the capacity of people with CD to learn and adapt to new challenges is situation-dependent and therefore highly variable: Capacity is determined not only by intrinsic factors, but also by the opportunities for learning and action afforded by the environment.

Male Partner Violence refers to the use of coercion, threat or force by men, in the context of intimate relationships, to subordinate and control women or same-sex partners. It may include acts of physical violence, such as pushing, hitting, kicking and beating; sexual violence and exploitation; emotional and psychological abuse, such as insults, belittling, humiliation, and intimidation; and, controlling behaviors, including isolating a woman from her family, monitoring her movements, and, restricting her access to financial resources, education, employment, or sexual and reproductive health care (World Health Organization, 2012).

PREVALENCE OF MALE PARTNER VIOLENCE AGAINST WOMEN WITH CD

- A popular misconception is that women with CD never ‘grow up’ or form adult relationships, and are therefore unlikely victims of male partner violence. However, the research shows that the majority of women with (mostly mild) CD will marry or enter into a common-law relationship, although they are somewhat less likely than other women to do so. Savage and McConnell (2016), for example, utilized data from the 2009 Canadian Community Health Survey to investigate the marital status of women with disabilities. The sample included 424 women with CD (comprising 1% of the sample), based on self-reported cognitive impairments and associated activity limitations. The study found that 58.8% of these women were either married or in a common-law relationship, or had been married at one time.
- There is a growing awareness that women with CD face a heightened risk of violent victimization, beginning in childhood and continuing into adulthood. The available data indicate that Canadian women with CD face a three to four-fold greater risk of male partner violence, compared with non-disabled women (Cotter, 2014; Martin, Ray, Sotres-Alvarez, et al., 2006). The General Social Survey on Canadians’ Safety revealed that more than four in ten women with CD have experienced male partner violence (Cotter, 2014). Furthermore, researchers suggest that women with CD are more likely to experience multiple forms (e.g., sexual, physical, psychological, financial) and incidents of violence, over a longer period of time, and with a greater number of male partners (Powers, Renker, Robinson-Whelan, et al., 2009).

Violence toward women with CD, including the many ways in which women with CD are denied their right to determine their own lives, is in some respects culturally condoned (i.e., viewed as ‘natural’ or ‘rational’): What counts as violence toward non-disabled women may not be counted as such when the victim is a woman with CD.



Women with CD experience forms of abuse that are rooted in ablest assumptions or the idea that persons with disabilities are afflicted, inferior and of less worth. Perpetrators may, for example, use verbal abuse, including insults about a woman’s intelligence, e.g., labelling her dumb or stupid, as a form of control.

- Reproductive control is one form of violence affecting a disproportionate number of women with CD. Male partners may exert control over a woman’s reproductive choices by sabotaging or refusing to use contraception; or, attempting to influence the outcome of pregnancies by restricting their access to reproductive health services, or coercing them into an unwanted abortion (Moore, Frowirth & Miller, 2010). Violent partners are not the only people who exert reproductive control over women with CD. Decisions over contraceptive care are often made for rather than by women with CD, and in some cases they may be pressured by family members or service providers into terminating a pregnancy or undergoing surgical sterilization (Björnsdóttir, Stefánsdóttir & Stefánsdóttir, 2017; McCarthy, 2009, 2014).

- Countering assumptions of passivity, dependency and victimhood, researchers have highlighted the resistance of women with CD to male partner violence. Interviewing women with CD who had been battered and or in other ways abused, McCarthy, Hunt and Milne-Skillman (2017) found that resistance could take many forms, such as standing up to their abusive partners, using contraception secretly, and eventually ending the violent relationship. Pacheco and McConnell (2017) report like findings from their study of mothers with CD in Alberta and Quebec. They also observed that motherhood provided the women with a resistance identity. Being a mother was an inherently meaningful and valued identity; by asserting their identities as mothers, the women derived self-worth and the capacity to resist internalizing their partner's derision and taunts.

IMPACT OF MALE PARTNER VIOLENCE

- Male partner violence affects women's economic security, relationships (including relationships with family, friends and children), and their health and well-being. Moreover, **women may suffer the effects of victimization long after the violence has stopped**. Many survivors suffer posttraumatic stress and or stress related health conditions (Golding, 1999; Pill, Day & Mildred, 2017).
- The health effects of male partner violence can include physical and psychological injury, chronic pain, neurological symptoms, gastrointestinal symptoms, sexual and reproductive health issues (e.g., urinary tract infection, chronic pelvic pain, unwanted pregnancies, termination, premature labor and miscarriage, stillbirth), and ongoing mental health problems (Public Health England, 2015).
- Male partner violence can erode a woman's sense-of-self (i.e., how a women thinks or feels about herself), and produce feelings of helplessness. When male partner violence occurs together with poverty and disability-based social exclusion the negative effects of each—including stress, powerlessness and social isolation—may be magnified (Matheson, Daoud, Hamilton-Wright, et al., 2015).
- Male partner violence is associated with elevated rates of depression, trauma symptoms, and alcohol and drug abuse among victim-survivors with and without CD. Matheson et al. (2015) note that women may turn to drugs or heavy drinking as ways to cope with stress and trauma, or escape '*in situ*'.
- Posttraumatic Stress Disorder (PTSD) affects as many as two out of three survivors of male partner violence (Golding, 1999). Women with CD are more likely than others to have had multiple victimization experiences, including abuse in their own upbringing, and are consequently at greater risk of developing PTSD (Pill, Day & Mildred, 2017).

The trauma of male partner violence challenges those (usually unconscious) assumptions that enable us to journey through life with confidence and well-being. These include (1) the assumption that one's self is worthy and competent, (2) the assumption that one's material and social 'environments of action' are safe and dependable, and (3) the assumption that the events of one's life are ordered and meaningful.

- Male partner violence can have a significant effect on a woman's experience of motherhood. Guilt and shame is a common response, and this can interfere with a mother's ability to be emotionally available and responsive to her children (Elliott, Bjelajac, Fallot, et al., 2005). Trauma related issues such as problematic alcohol use, depression, fear of intimacy or authority, hypervigilance and emotional numbing can also impair self-regulation, and in turn, parenting skills. Notwithstanding, there is evidence that some mothers who experience male partner violence compensate and are more-than-ordinarily sensitive and responsive to their children (Letourneau, Fedick & Willms, 2007).

Trauma effects can be misunderstood by those involved in the lives of women with CD and this can contribute to re-traumatization, unhelpful interventions and a negative labelling of behavior (or of women with CD) as "bad", "angry", "avoidant" or "non-compliant" or, as having "limited capacity".



PRACTICE POINT 2. Screening for trauma

PTSD in women with CD may go undiagnosed and untreated due to diagnostic overshadowing. This occurs when symptoms of PTSD, including but not limited to impaired cognitive and meta-cognitive (e.g., the regulation of emotion) functioning, are mistakenly attributed to, or assumed inherent to a woman's CD. Trauma screening tools designed for persons with CD have been developed, including the Impact of Event Scale-Intellectual Disabilities (Hall, Jobson & Langdon, 2014), and the Lancaster and Northgate Trauma Scales (Wigham, Hatton, & Taylor, 2011). These tools may be useful to community outreach workers for the purposes of screening and referral.

PRACTICE POINT 3. Respect for autonomy

The notion that women with CD are inherently vulnerable, or 'childlike', can elicit paternalistic responses from service providers, reducing the ability of women to make decisions about their own lives (Dixon & Robb, 2016). Such paternalism may be re-traumatizing. A trauma-informed approach maintains respect for women with CD as autonomous subjects, and addresses their need to feel in control over the process.

- Research shows that many CHILDREN who witness male partner violence toward their mothers are affected short and long term (Devaney, 2015). One meta-analysis, which pooled data from 118 separate studies, showed that these children tend to experience poorer developmental health, and often display internalizing and or externalizing behavior problems (Kitzmann, Gaylord, Holt & Kenny, 2003).

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PRACTICE POINT 4. Help for children

Mothers with CD affected by male partner violence are often concerned about their children's short and long-term safety and well-being (Pacheco & McConnell, 2017). Community outreach workers can **ally with mothers with CD** to ensure that their children receive any specialized help they may need.

UNDERSTANDING MALE PARTNER VIOLENCE AGAINST WOMEN WITH CD

- Male partner violence toward women with CD has been linked to cultural beliefs or 'ideas' about what it means to be female in relation to male, and disabled in relation to 'able'. The doubly subordinate social status and perceived inherent vulnerability of women with CD is thought to disinhibit male partner violence. Scior (2000) concluded from listening to women's experiences that gender and disability equate to double jeopardy, whereby women living with disabilities in a patriarchal society are left more disempowered and are more vulnerable to domestic abuse than women without disabilities.

Victimization is neither a natural nor an inevitable consequence of CD: There is nothing about CD that causes male partner violence. Such violence is secondary to social responses to women and girls with CD, including their devaluation and marginalization.

Violence against girls and women with disabilities is "compatible with a culture of sexism and ableism that [subordinates women], pathologises difference, individualizes impairment and maintains ableism" (Goodley & Runswick-Cole, 2011, p.609)

To the extent that women with CD internalize ideas about what it means to be female in relation to male, and disabled in relation to able, including societal expectations of passivity, dependency and victimhood, they are rendered more vulnerable to violence. Through countless dehumanizing social interactions, many women with CD are conditioned to feel worthless, to accept as 'natural' their subordinate social position, and may even come to see themselves as deserving of mistreatment (Copel, 2006; Pyke, 2010).

- Many women with CD have been made to feel different their entire lives. Entering into an adult partner relationship [and having children], is an expression of ordinariness, and may be viewed as a pathway to adult status and the respect this engenders. Pestka and Wendt (2014) observe that women with CD "fight very hard to conform to ascriptions that give women value, and possibly settle with or accept abuse in their lives to gain social value that has often been missing throughout their life course" (p. 1042).

Practitioners said ...

They look at it as if it's normal – it's something that is happening to me, and it's been happening since I was a little kid, and it's just normal for me to go through this

Partner Violence against Women with CD

- Women with CD have the same basic need for intimacy and belonging as others, but typically have fewer social connections, or opportunities to meet potential partners and form relationships. A relationship with an abusive partner may seem preferable to the social isolation and loneliness to which they are accustomed. Landman (2014) suggests that, “Given [that women with CD have] so few opportunities for relationships that bring warmth, mutual support and validation, then often any connection is better than none” (p.359). Similarly, McCarthy (2014) observed, “As long as the most, and sometimes only, valued thing in a woman’s life is her relationship with a man, this will leave her emotionally and psychologically dependent and vulnerable to exploitation and abuse” (p. 5).
- Many of the known risk factors for male partner violence are more prevalent among women with CD. Such factors include but are not limited to childhood abuse, low educational attainment, unemployment, poverty, neighborhood deprivation, social isolation, and (related to all of these factors) poorer physical and mental health (Brownridge, 2006). Women with CD who experience less disadvantageous life conditions (e.g., supportive upbringing and social network, education and employment opportunities, better health) are substantially less likely to experience male partner violence (Iudici, Antonello & Turchi, 2018).

Women with CD are more likely to be targeted for violence, less likely to be able to identify and react to such violence, less likely to report such violence, and less likely to be believed when they try to report such violence (Meer & Combrinck, 2015).

BARRIERS TO ENDING AN ABUSIVE RELATIONSHIP

- Many women with CD, including those affected by Fetal Alcohol Spectrum Disorder (FASD), have difficulty making connections between ‘causes’ and ‘effects’; regulating their thoughts, emotions and behaviors; understanding and communicating their choices; and, planning and organizing to bring about desired changes (CAMH, 2019). Such personal challenges may partly explain why women with CD tend to stay in abusive relationships longer than others. Notwithstanding, workers must guard against the assumption that CD is ‘the problem’: With appropriately adapted support, women with CD can make informed decisions; advocate for themselves and their children; and, formulate and follow through with a plan of action to end an abusive relationship (Dixon & Robb, 2015; McCarthy, 2016).
- Women and girls with CD are less likely than their non-disabled peers to receive formal or informal sexuality and relationship education, due in part to a widespread (but false) assumption that they have little or no interest in intimate partner relationships. McDaniels and Fleming (2016) observe that, even when formal education is provided, it is often indirect, vague, euphemistic or overly technical, resulting in limited learning and application. Consequently, some women with CD may have limited understanding of their sexual and reproductive health and rights or the dynamics of abusive relationships, and in turn, may be slower to recognize partner violence as such (Eastgate, Van Driel, Lennox & Sheermeyer, 2011; Schaafsma, Kok, Stoffelen & Curfs, 2015).

- Male partner violence, including coercive and controlling behavior, erodes the psychological resources needed to end a violent relationship, including a sense-of-control or self-efficacy. Walter-Brice, Cox, Priest and Thompson (2012), for example, interviewed women with CD and found that all, at various stages, had internalized the oppression of their partners. The psychological impact of this resulted in the women experiencing feelings of powerlessness and self-blame.
- Women with and without CD may delay leaving, or return to an abusive relationship due to the threat or fear of retaliatory violence. Furthermore, perpetrators often isolate victims from their family and friends, i.e., limiting their access to sources of social support, and or restrict their access to economic resources, as a means of enforcing dependency. Given that women with CD typically have smaller social networks and low incomes, they may be particularly vulnerable to such coercive control tactics.

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PRACTICE POINT 5. Violence awareness

Some women with CD may have difficulty recognising abuse, or allowing themselves to believe that their partner is abusing them. The “Warning signs of abuse quiz”, designed for women with disabilities and published on-line (<https://www.dvrcv.org.au>), may be useful to community outreach workers for the purposes of counseling or education.

- The possibility of losing custody of one's children is a major deterrent to reporting male partner violence or leaving an abusive relationship, especially for women with CD who are widely and erroneously assumed to be inherently unfit for motherhood. Research shows that many mothers with CD live with the ever-present fear of ‘the welfare’ coming to take their children, and their fears are well justified: An estimated 30-40% of children born to women with CD will be taken from them and placed permanently out-of-home, and often due to factors over which they have no control. Walter-Brice et al. (2012) found that some of the women with CD in their study who had children had disclosed abuse to social services in desperation to leave the abusive relationship. However, “their pleas for help were dismissed; family work was implemented; when this failed and the abuse escalated, Social Services removed the children” (p.511).

Practitioners said...

Women who have experienced male partner violence often have difficulty trusting others and as a result may be reluctant to engage with services. Given that many women with CD have had negative experiences of services their entire lives, including experiences of loss of control, they may be more wary or reluctant than most to engage with the service system.

Without sufficient economic means, adequate income support provisions or access to employment opportunities, women with CD will have difficulty leaving an abusive situation, especially when a lack of economic resources is compounded by social isolation by a perpetrator (Mays, 2006)

- Women with CD face a number of barriers to obtaining support and assistance. Some of these barriers apply equally to all women who experience male partner violence, however some barriers are exacerbated by CD. One barrier is a lack of knowledge or accessible information about available supports and services. Another is the response of service providers, including but not limited to police and domestic violence services, which are often ill equipped in terms of training and resources to effectively accommodate their support needs (McCarthy, 2016). Issues for women with CD include not being believed when they disclose male partner violence, or receiving inappropriate responses resulting from incorrect assumptions or stereotypes (Douglas & Harpur, 2016).

Accessibility challenges faced by people with CD (see Yamon-Chamovitz, 2009)

Time pressure: People with CD often need more time to process information and react, to make up their mind, plan and implement a course of action. Under the burden of heavy caseloads, service providers may unreflectively impose tic-toc demands on clients with CD, rather than accommodating their temporal needs.

Complexity level: People with CD often have difficulty understanding abstract concepts, and or processing complex information or instructions. Unfortunately, when asked to simplify instructions and communication, service providers tend to comply by speaking louder or adopting a childish vocabulary or intonation.

Literacy: Accessibility means not only the right to enter and navigate a place, but also the right to receive 'easy to read and understand' information. Easy language translation, the use of infographics or pictograms, and alternative modalities (e.g. audio, video) can improve the accessibility and efficacy of services.

- Women may also face cultural barriers. In some cultural communities, violence within the family may not be considered violence or something that should be discussed outside of the family. Fernandez (2006) points out that in some cultural communities women are expected to bear a great deal of suffering without protest for the sake of the family. Women with or without CD may then remain in a violent relationship because they do not see separation or divorce as a viable alternative, and or they may not want to dishonor their family or lose the cultural ties that provide them with a sense of meaning and identity (Pacheco & McConnell, 2017).

A woman's culture, including her worldview, is likely to have a fundamental effect on how she perceives male partner violence, the likelihood that she will disclose her experience, and whether or not she will seek assistance and what type of assistance she will be inclined to accept.

A CULTURAL SAFETY APPROACH TO SUPPORTING WOMEN WITH CD

- A cultural safety approach necessitates the understanding that the vulnerability of women with CD, including indigenous and non-indigenous women, to male partner violence is created and sustained by patterns of cultural value that constitute women and people with disabilities as comparatively unworthy of respect, and by exclusionary social arrangements. Male partner violence is a social rather than an individual problem.
- Cultural safety involves reflexive practice, defined as the active analysis, or self-conscious consideration of how our ‘knowledge’ about others is generated, and how implicit assumptions and relations of power operate in this process, followed by action rooted in a deepened understanding of the culture we bear, as well as recognition and respect for diversity.
- Cultural safety underscores the importance of (1) understanding what male partner violence as well as proposed supports and services mean to victims-survivors (Fernandez, 2006), and (2) deconstructing power imbalances, in order to establish worker-client relationships characterized by understanding, trust, respect, honesty and empathy (Keesler, 2014; Smye, Josewski & Kendall, 2010).
- A cultural safety approach values the cultural resources of victims-survivors, including cultural models of healing or recovery, and traditional/ learned practices to promote safety and well-being. Women with and without CD are therefore engaged as collaborators, not only as a means to foster trust, but also because they have unique knowledge to contribute.
- “Operating within a cultural safety framework implies acceptance of the premise that the only person qualified to comment on the quality and ‘safety’ of the care provided is the recipient of care” (Richardson, 2004, p. 41). A conundrum for service providers is that women with and without CD need to feel safe in order to ‘comment’ or engage in the design and evaluation of services.

“It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity, and truly listening (Williams, 2002, p. 1).

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PRACTICE POINT 6. Enhancing the ability to be culturally safe

Critical reflection: Become mindful of one's own cultural identity and sociohistorical location in relation to service recipients, and of one's habits of mind, including ways of conceptualizing things like health and wellness.

Collaborative process: Promote collaborative practice in which those seeking help are also welcomed into a joint problem-solving approach as carriers of important information and know-how.

Mutual learning: Engage in mutual learning, frequent checking in to ensure that proposed action plans 'fit' with service recipient's values, preferences, and lifestyles.

A TRAUMA-INFORMED APPROACH TO SUPPORTING WOMEN WITH CD

- Trauma-informed practice means integrating an understanding of past and current experiences of violence and trauma into all aspects of service delivery. The objective is to avoid re-traumatizing individuals and support safety, choice, and control in order to promote healing (Poole, 2015).
- *Trauma awareness is the foundation for trauma informed practice:* Being ‘trauma aware’ means understanding the high prevalence of trauma in society, the wide range of responses, effects and adaptations that people make to cope with trauma, and how this may influence service engagement (e.g., difficulty trusting others, missing appointments, etc.).
- *Emphasis on Safety and Trustworthiness:* Trauma-informed practice is a way of being in relationship, rather than a specific treatment strategy or method. Safety (physical, emotional, cultural) is a necessary first step for building strong and trusting relationships, service engagement and healing. Service providers cultivate safety in every interaction and avoid confrontational approaches.

Practitioners said ...

My advice is to listen to their story before you start talking. It's respectful listening; hearing without judging what they're saying. Just really respecting what their experience is without being judgmental or pushing an agenda. This is their story; this is their life.

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PRACTICE POINT 7. Cultivating safety and trustworthiness

Safety and trustworthiness are established through such practices as welcoming intake procedures; adapting the physical space to be warm, comfortable and inviting; providing clear/accessible information about programs and interventions; allowing the expression of feelings without fear of judgement; being predictable/dependable (e.g., if you say you are going to do something, do it), and creating safety plans and advance directives for responding to crises (Ministry of Children and Family Development, 2016).

Practitioners said ...

Sometimes it's about allowing yourself to be very open and honest, to tell my client "I am really scared for you" and wait for that point where they say, "I just don't know what to do". I'm not rushing in with answers and telling her what to do. I wait until I hear her ask, then I can provide her with the information she asked for.

Understanding an individual woman's life context, the strengths she has exhibited, and the adaptations she has made to survive the violence in her past is crucial to creating a therapeutic alliance (Elliott, et al., 2005).

- *Choice, collaboration, connection:* A key aspect of trauma-informed practice is to create an environment where clients do not experience re-traumatization, i.e., the sense of powerlessness or loss of control associated with past traumatic events. **Trauma-informed practitioners recognize and respect the need and right of women with CD to choice and control in decision-making.** See Practice Point 8.
- *Strengths-based and skill focused:* A trauma-informed approach accentuates the positive, recognizing each woman's individual strengths and accomplishments, and seeks to build on and enhance her skills (e.g., skills in recognizing and managing trauma symptoms, skills for negotiating relationships and leading safer sexual lives).

Practitioners said ...

It's really important to meet them where they are at. And sometimes that might be different from where we think they should be at. And try to understand why they might be making some choices... and that takes really listening to their story and understanding the different parts of their story. That's when you're able to build that trust, and you're able to connect with them

PRACTICE POINT 8. Support for decision-making

1. Assume that women with CD have the capacity (with support) to make decisions.
2. Remind other workers that capacity to make decisions should always be assumed.
3. Understand that women with CD have the right to receive the information and support they need to help them make and voice their decisions.
4. Be sensitive to environmental factors that could affect a woman's ability to make choices, free of discrimination, coercion and violence.
5. Help women to get information as required, in accessible formats, to help them understand their options, 'weigh up' potential risks and benefits, and make decisions.
6. Check for understanding, for example, by asking a client to explain in their own words the choices available to them. (See Practice Point 10).
7. Identify, seek out and make available any other supports required to assist women with CD in making their own decisions and acting upon them.
8. Provide opportunities for women to speak candidly about how they feel, at their own pace; encourage women to voice any fears or concerns they may have.
9. Understand that it is difficult to make decisions about some issues, and that it's normal to not have an answer straightaway. **It may be helpful to break decisions down into smaller components.**
10. Encourage women with CD to make up their own mind about what they think; remind women that they have the right to make decisions, and to change their mind.

SUPPORTING WOMEN WITH CD AFTER THE INITIAL CRISIS OF LEAVING

Practitioners said ...

One of the most important skills is learning to be flexible and adaptable; recognizing that when you're working with a person with some cognitive challenges it isn't going to be straightforward. You need to be able to think on your feet, adjust in the moment and respond to what their need is. That flexibility, that willingness to just sort of go where they take you, is really important.

Thinking about the support needs of women with CD after leaving

What kind of changes does she want to make?

What is her timeframe for achieving these changes?

Are the changes achievable?

What resources or services does she need to make these changes?

What are the barriers to making these changes?

- Support for women with CD after the initial crisis of leaving an abusive situation should be highly individualized, reflecting their stage of journey, the practical reality of their life situation, and their personal priorities and preferences. Notwithstanding, researchers suggest that it may be necessary to address immediate safety and health issues and help women secure basic resources or life needs before skill-building and meaning-work can begin in earnest (Elliott et al., 2005). However, rather than compartmentalizing support, it may be helpful to think of meaning-work as encapsulating the tasks of securing one's safety and life-needs as these involve taking charge of one's life (See Figure 1).

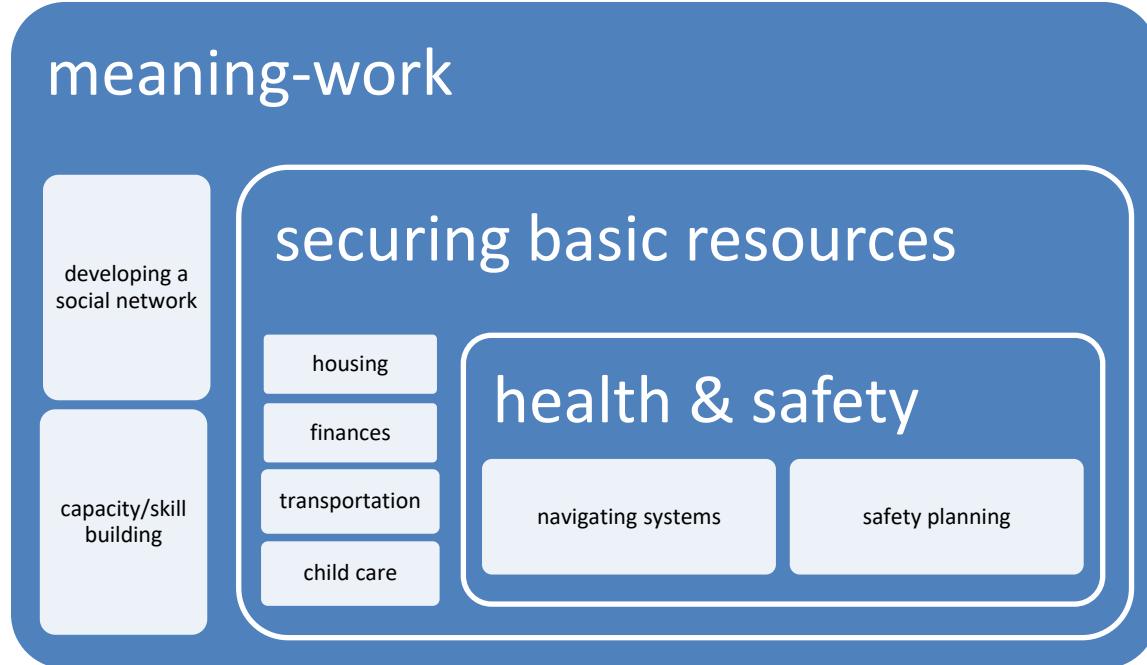


Figure 1. Supporting women with CD in the aftermath of male partner violence

Safety Planning

- Leaving an abusive relationship is a complex process rather than an event. The process may take years and include multiple attempts before a woman permanently ends the abusive relationship. Many women continue to be harassed, intimidated and in some cases assaulted by their ex-partners (McCarthy et al., 2017). Coercion and controlling tactics may continue throughout the leaving process affecting their decision-making and capacity to exercise agency. Furthermore, for women with CD who have children, contact or communication with their abusive ex-partner, and the fear associated with this, may continue indefinitely as they are forced to negotiate and manage co-parenting. Safety planning is therefore an ongoing process.

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PRACTICE POINT 9. Safety planning is an ongoing process

Safety planning is not a onetime event, but rather an ongoing process. As the life circumstances of women with CD affected by male partner violence change, safety planning must address emerging risks.

- Safety planning generally involves more than merely providing women with information, including contact information for local and national resources, such as local domestic violence, legal, law enforcement, and social agencies. It involves assessing danger, and coming up with simple, realistic, clear and specific safety strategies (i.e., specific to each woman's unique situation) that a woman who is at risk of further abuse can use to promote her physical and psychological safety, and the safety of her children, across a wide range of situations or scenarios. Safety planning may include the creation of advance directives, detailing how the client, service providers and significant others (e.g. family members) will respond in the event of a crisis.

Navigating Systems

- Community outreach workers have an important role in helping women with CD connect to the supports and services they may need after the initial crisis of leaving a violent situation. This may involve helping women to identify their support needs and set goals, which may incorporate the use of screening tools (e.g., screening for trauma symptoms); the provision of accessible information about available services (e.g., housing, legal aid) or community resources (e.g., food bank, leisure options); and, when appropriate, making referrals (e.g., for mental health and addictions services, or parenting and family support services).

Practitioners said ...

Providing information or making referrals may not be enough to ensure that women with CD seek out or obtain the support they need. Due to their fears, a lack of transportation, and/or any difficulty they may have with understanding or 'speaking up', it may be necessary to accompany women with CD to appointments, and advocate, ensuring that those services are appropriately matched to the woman's ability level, and respectful of her wishes and concerns.

Securing basic resources or life-needs

- After the initial crisis of leaving, many women with and without CD face the challenge of securing basic resources or life needs, including but not limited to basic health care, housing, income support, transportation and childcare, and or have to deal with child custody issues and other daily stressors and hassles, including dealing with sometimes intrusive family members, friends and authorities. High levels of stress or anxiety associated with such material insecurity can interfere with a woman's ability to think, learn and problem-solve. McDonald and Dickerson (2013) found that women focused on nurturing their self-recovery only after they had secured basic resources and were financially stable. Helping women secure basic resources or address immediate stressors should be considered a priority, second only to helping her secure her safety, and that of her children.

It is important to consider that we all generally have more relationship and parenting knowledge than we use. Stress impairs self-regulation, and self-regulation is key to translating what we know into action. The key point here is that a lack of knowledge or skills is not always the issue. Addressing chronic stressors (such as financial hardship, poor housing, neighborhood safety, poor physical health, social isolation, victimization, and so on) can enable clients to apply more of what they know more consistently.

Capacity/Skill-building

- Capacity-building is the process of increasing a woman's knowledge and decision-making skills through education. This may include the knowledge and skills needed to (a) identify the risks and benefits of seeking help, and advocate for greater control in decision-making; (b) prevent and manage symptoms of trauma or chronic health conditions; (c) regulate her emotions; (d) use strategies to promote safety and reduce risk of re-victimization; (e) develop a network of mutually respectful and satisfying peer relationships; (f) develop a meaningful routine of family life, and positive parenting strategies; and, (g) access employment or training opportunities (Ford-Gilboe, Wuest, Varcoe & Merrit-Gray, 2006). Another potential focus of capacity-building may be on skills for community living, such as managing on a budget.
- Several resource kits and training programs designed for women with CD have been developed. The Looking After Me Resource Kit (<http://www.daru.org.au/resource/looking-after-me-resource-kit>) for example, may be useful as a teaching aid with some women. This kit can also be used as a professional development tool to help services become more inclusive and better able to meet the needs of women with CD regarding relationships and male partner violence issues. Examples of research-informed training programs include "Take Care of Me" (Bowen, 2000), "Feel Safe" (Mazzucchelli, 2001), "A Safety Awareness Program for Women with Disabilities (ASAP)" (Robinson-Whelen, Hughes, Gabrielli et al., 2014), and "Escape-DD" (Hickson, Khemka, Golden & Chatzistyli, 2015).

"The key coping task of trauma survivors is to rebuild a viable assumptive world that can account for their victimization and yet offer a nonthreatening, relatively positive view of the self and the world" (Jirek, 2017, p.168)

- Some research-informed guiding principles for capacity-building education for people with CD can be derived from the literature (Harader, Fullwood and Hawthorne, 2009; McDaniels & Fleming, 2016). Education for people with CD is likely to be more effective when it is skill-focused, matched to the learner's ability level, and responsive to the learner's felt needs. The research further suggests that the efficacy of skill-building interventions is enhanced when information is provided in a variety of formats; techniques such as modeling, role play, and practice with faded prompting are used; and, when learning is positively reinforced.
- Another approach, or complement to 'safety training', involves the use of participatory methods. Rather than starting with a pre-fabricated curriculum of safety knowledge and self-protective skills, a participatory approach begins with the individual and shared experiences of participant-learners. Key process elements include dialogue, critical reflection in a group, and collaborative problem solving. Outcomes may include increased awareness (e.g., of negative habits of thought and action); engagement with and practice of (new) ideas, such as, "I am worthy of respect"; and or, collective action to address social barriers (e.g., how police services respond to and handle the reports of women with CD).

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PRACTICE POINT 10. Checking for Understanding

It can be difficult to know if a person with CD understands questions asked or information provided. 'To be safe', people with CD may feign understanding (agreeing with statements or answering "yes" to questions regardless of their content), and or voice opinions or comments that they have 'borrowed' from others. It is also important to keep in mind that people with CD are socialized to be compliant, and are therefore more likely to acquiesce.

To facilitate understanding and informed choice:

Primary communication should always be with the woman: resist the temptation to address questions to others such as an accompanying significant other or 'benefactor'.

Questions or information should be broken down into small chunks. Use short, simple sentences with everyday words, and avoid jargon.

Present questions in an either/or rather than a yes/no format, but care must be taken to ensure that the person is not simply repeating the final option given.

It is essential that people with CD are given time to formulate a response. It may be necessary to rephrase a question, but doing so too quickly may create confusion.

Include the option of answering, "I don't know", to questions and make sure the individual knows that it is OK to say this.

Ask the person for examples illustrating points covered (e.g. If I was in this situation, what could I do?), and or ask them to tell you how they might explain the point to others.

"Effective support need not be institutionalized or highly structured. Informal networks of support and spontaneous expressions of support and encouragement in both clinical practice and personal encounters may also prove effective in preventing further harm to women who have already suffered abuse" (Coker, Watkins, Smith & Brandt, 2016, p.266)

One example of a participatory approach to sexual safety education for people with CD is the "Living Safer Sexual Lives" project. Johnson, Frawley, Hillier and Harrison (2002) established a reference group of adults with CD, advocacy organizations and service providers. Twenty-five adults with CD were invited to share their life stories, with a focus on sexuality and relationships. These stories were then used in developing workshops and information resources (e.g., videos) for women with CD, families and service providers, including a workshop on 'having rights and being safe'. The workshops were non-prescriptive, and responsive to participants' concerns. The stories were used to generate discussion, and participants' drew on their own experiences, with input from the facilitators, to explore their values, beliefs and expectations.

Developing a Social Support Network

- Having a strong network of relationships helps safeguard women with CD from violence. Social support can also reduce the impact of partner violence on women's health and well-being. Coker, Watkins, Smith, et al. (2003), for instance, found that perceived social and emotional support moderates the effects of male partner violence: Women experiencing higher levels of social and emotional support reported better mental health, including fewer and less severe symptoms of PTSD.

Practitioners said ...

When women with CD end their relationships with their abusers, it often changes the dynamics of all their relationships. Women with CD may then need support renegotiating relationships with friends and family members. This may include help with determining the trustworthiness of friends and family members, setting boundaries, and reconnecting or mending friendships that had been damaged during the abusive relationship as a result of being isolated by their violent partners.

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PRACTICE POINT 11. Engaging the support network

With the woman's agreement, it may be appropriate to identify her natural supports and include them in the process. The outreach worker can assist the client and natural supports to come together to formulate a support plan. The Support Interview Guide (see Appendix 1), which was developed for mothers with CD, may be a useful tool for facilitating a conversation with women with CD about their support network and social relationships, and identify who might be engaged in the process of support planning.

Meaning Work

- The repercussions of male partner violence may include loneliness, despair, guilt, confusion, fear and a diminished sense-of-self (Childress, 2013). Matheson et al. (2015) observed that male partner violence creates an erosion or dissolution of the self. As a result, a woman may experience an immobilizing sense of worthlessness and helplessness, resulting in a reduced ability to take steps to change her situation. The path to 'recovery' or healing then involves 'meaning-work', a process through which women endeavor to make sense of their experience; recognize and revise negative habits of thought, or internalized abuse (e.g., self-blame, distrust of others); and, to re-story their lives, and rebuild or redefine their sense of themselves as autonomous agents.
- Jirek (2017) suggests that, with appropriate training, workers can help survivors integrate the trauma into their lives; to articulate their identities before and after the trauma; to identify the discontinuities between these iterations of self; to grieve the losses; celebrate their strengths and accomplishments; and, reconstruct a narrative or life story that affirms the positive aspects of the self while also recreating meaning in life and a hopeful vision for the future. It is however critical that workers (1) not hold specific expectations of meaning-making for the client, and instead expect that each individual will heal at her own pace and in her own way; and, (2) recognise the limitations of their own training and skills, and make referrals as needed to ensure that each victim-survivor of male partner violence receives any specialised assistance they may need with the meaning-making process.

Practitioners said...

"Sometimes the most important thing you can do is build their confidence and self esteem"

Practitioners said...

Workers may assist women with CD with meaning-work by:

- *Listening carefully and non-judgmentally to their stories.*
- *Educating women on how male partner violence can impact negatively on how they perceive or think about themselves, their lives, and others.*
- *Acknowledging a woman's strengths and accomplishments, including her resilience as a survivor and her moves toward safety however tentative these may be.*
- *Affirming her identity as mother, recognizing that a woman's success in providing for her children may provide her with an initial means of redefining her sense of self and self-worth after leaving.*
- *Helping women develop and orchestrate new routines of everyday life incorporating self-nurturance, and engage positively in new roles and relationships.*
- *Women may also benefit from peer mentoring or support groups, which offer validation, connectedness (e.g., the knowledge that she is not alone), and positive role models.*

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Support Interview Guide

Who's there for you?



Family Support and Services Project

Support Interview Guide

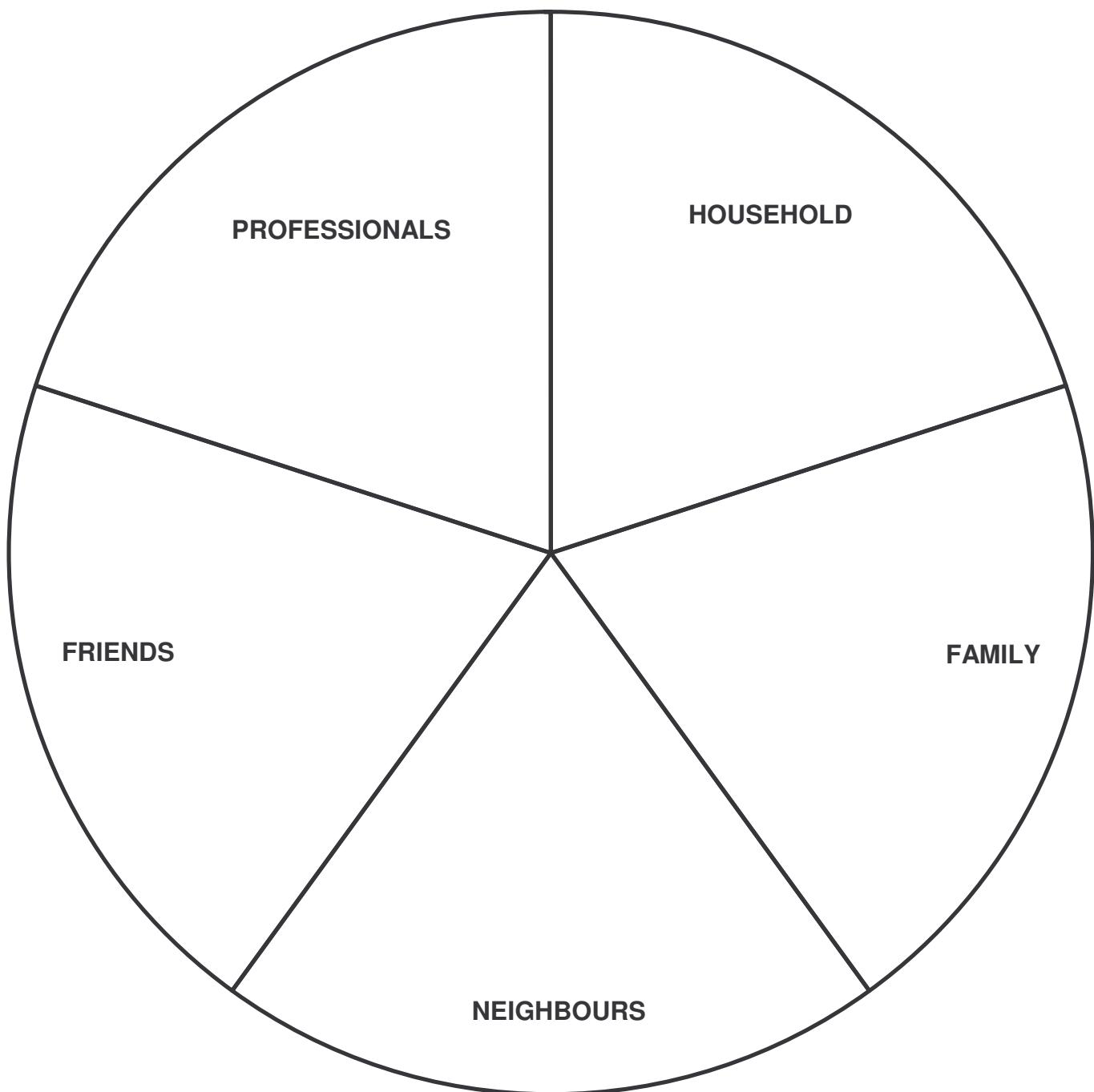
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Family Support & Services Project
School of Occupation & Leisure Sciences
Faculty of Health Sciences
The University of Sydney

2000

Based on the work of:
House, Umberson & Landis, 1988
Tracey & Whittaker, 1990
Llewellyn, McConnell & Bye, 1995

1/

The first thing we need to do is list the names of people who support/help you, and people who you turn to for support/help when you need it. We are not going to list the names of everyone you know, just those people who support/help you most (no more than 10 people). Think of people that you talk to when you are worried, angry, or upset. Think of people who help you in practical ways, like filling out forms, lending you money, or baby-sitting. Think of people who you go to for advice or information. Think of people you like to go out with, or just spend time with. We are going to write their names in the segments of this pie.

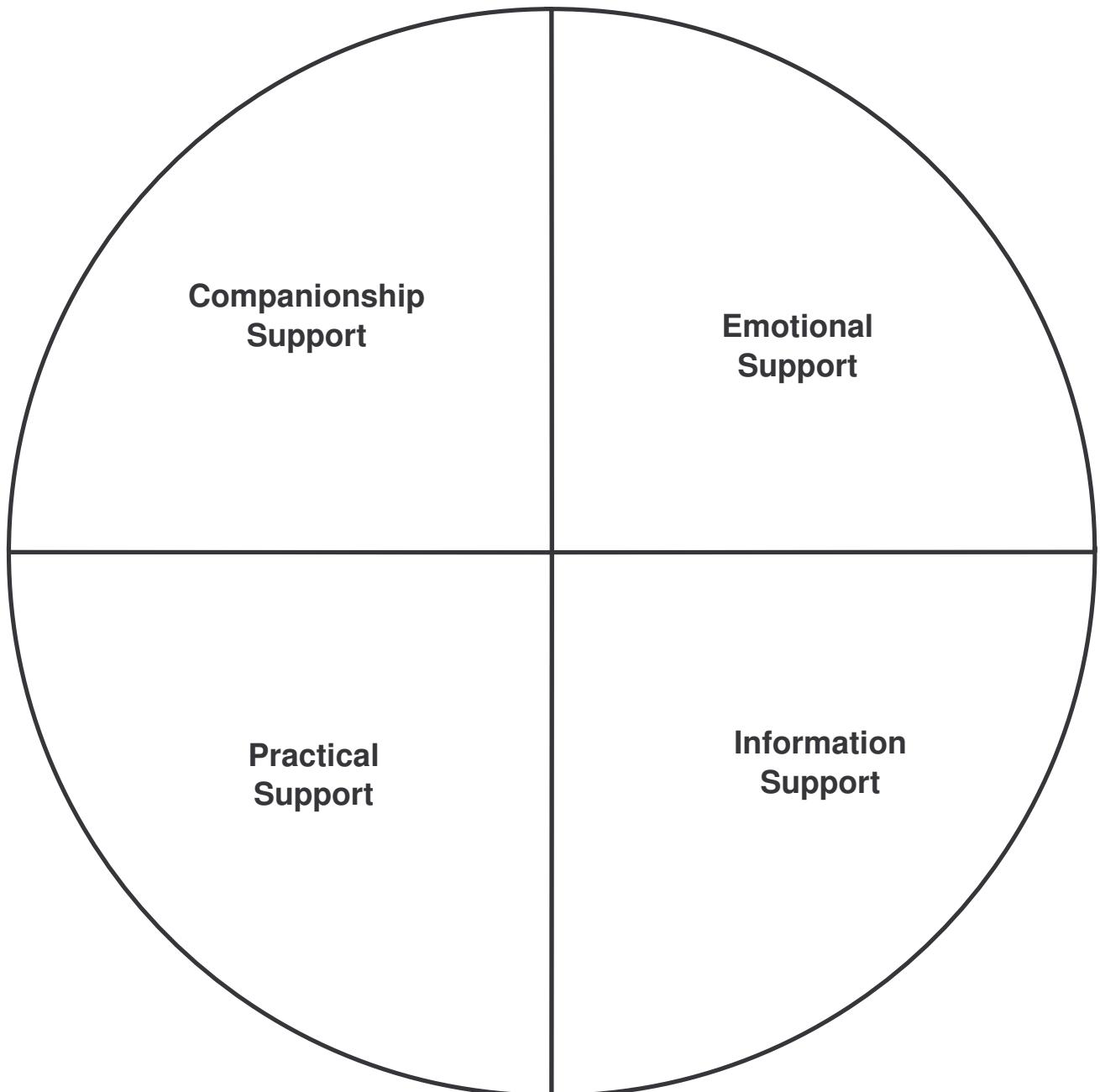


2

Now we're going to put the names of those same people onto another chart. This time, we are arranging them according to the type of support they give you. We have divided support into 4 different types.

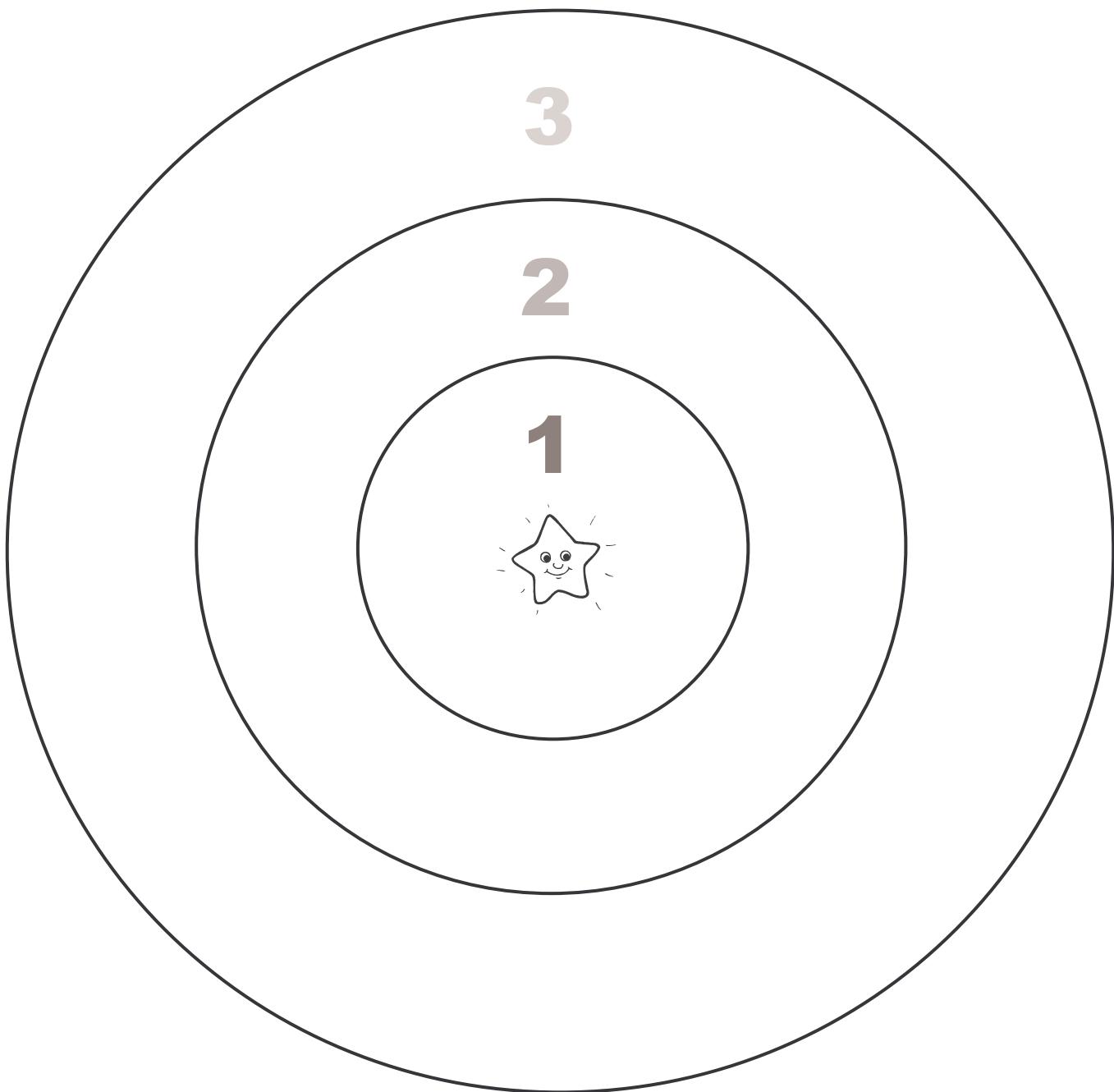
Show support cards (*Explain each type of support to parents and ask them for another example to check their understanding.*)

For each of the support people we have talked about, what kind of support do they provide (each person can provide more than one type of support). We will write their names in those sections of the circle.



3

Now we're going to put the names of those same people onto another chart. This time, we are arranging them according to how close you feel to them. In the inner circle (1), let us put the names of the people who you are so close to, that it is hard to imagine life without them. In the middle circle (2), let us put the names of people who are not that close but are still very important, and in the outer circle (3) let us put the names of people who are not as close as those in the middle circle but are still a support to you.





Now let's look at each of these people in turn. Let's list them, from closest to most distant.

Nearby

Walking distance

Not far

**A short & easy trip by car or public
transport**

Far

A long or difficult trip

Very Far

Too far for a day trip

Every day

More than once a week

Weekly

Fortnightly

Monthly

A few times a year

Maybe once a year

Less than 3 months

3 -12 months

1-5 years

More than 5 years

Not at all comfortable

A little uncomfortable

Comfortable

Very comfortable

They mostly help you

You help each other

You mostly help them

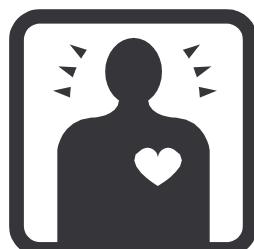


Information Support

- ✓ Telling you things you need or want to know
- ✓ Answering question
- ✓ Giving you good advice



Emotional Support



- ✓ Cares about your feelings
- ✓ Listens to your problems
- ✓ Makes you feel good about yourself



Practical Support



- ✓ Helping around the home
- ✓ Helping fill out forms
- ✓ Driving you places
- ✓ Helping with money
- ✓ Baby sitting



Companionship Support

- ✓ Getting together for a chat
- ✓ Going out for coffee
- ✓ Doing things together like shopping or things you both enjoy



QUIZ: Warning signs

Can this be happening to me? This is a question many women ask themselves.

It can be difficult sometimes to let yourself believe you are being abused. It can be hard to admit you are being abused because the person hurting you doesn't always act this way – sometimes they may be loving and kind.

It can be difficult to admit you are being abused because you love or depend on the person and maybe you are scared about what life will be like without them.

But if you often feel afraid of upsetting this person, and you change what you do to make sure they don't get angry with you, then this is a sign that you are being abused.

Warning signs of abuse quiz

Are you feeling worried about your relationship but not sure if there is abuse involved? Take a few minutes to fill in the **WARNING SIGNS QUIZ** below.

Does your partner, your boyfriend or girlfriend, your friend, your carer, or a family member:

- make you feel uncomfortable or afraid?
- often put you down, make fun of you, or make you feel worthless?
- always check up on what you're doing or where you are going?
- try to stop you from seeing your own friends or family?
- make you feel that no one will believe you if you say you are unhappy?
- stop you from having any money yourself or tell you what you can and can't spend money on?
- refuse to help with your personal support needs when you ask?
- make you feel afraid to disagree or say 'no' to them?
- tell other people you make things up and easily get confused?
- scare or hurt you by being violent (eg. hitting, choking, smashing things, breaking or removing disability aids, locking you in, driving dangerously to frighten you)?
- pressure, force or trick you into doing sexual things that you don't want to do?
- insist in always going in to see the doctor with you?

- threaten you with losing your children?
- threaten you that you will have no one to help you if you leave the relationship?
- threaten you that will be placed in an residential accommodation service?
- threaten to hurt you if you say you want to end the relationship?
- have your children heard or seen these things or been hurt themselves?

If you have answered ‘yes’ to any of these, then there are signs that you are not being treated right, or that you are being abused. If you don’t feel safe, respected and cared for, then something isn’t right.

Remember, if you are being abused, it’s not your fault. Just because someone has treated you badly, it doesn’t mean there’s anything wrong with you. They are the one who has done the wrong thing. You are not to blame for the abuse.

You have the right to feel safe and to live a life free from fear.

I know now, having been out of it for almost ten years that I was so accustomed to being abused that I just accepted it as being what I deserved.

Source URL: <https://www.dvrcv.org.au/knowledge-centre/quizzes/quiz-warning-signs>