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EDUCATION

Doctor of Philosophy May 2022 Dissertation Title	School of Social Work University of Maryland Baltimore The Interplay of Home Visitors' Personal and Professional Identities in Effectively Screening and Supporting Women around Sensitive Topics
Master of Social Work 2006 Focus	School of Social Work Virginia Commonwealth University Macro Practice
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SCHOLARLY INTERESTS

- To investigate influencing community and social factors impacting general health within at-risk populations with an emphasis on social justice and community risk factors. Such investigations include the influence of reproductive freedom, sexually transmitted infection risk, affordable housing, chronic disease, domestic violence, primary and secondary education outcomes, social inequities, and overall community crime statistics with a focus on improving the well-being of groups with health disparities.

TEACHING INTERESTS

- Social work student practice within the field setting.

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Abstracts

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Abstract

Title of Dissertation: The Interplay of Home Visitors' Personal and Professional Identities in Effectively Screening and Supporting Women around Sensitive Topics

Karen M. Burruss-Cousins, Doctor of Philosophy, 2022

Dissertation Directed by: Bruce DeForge, PhD

Home visiting programs provide information, support, resources, and tools that empower new parents to promote positive maternal and child health outcomes. During home visits, there is a unique opportunity to screen for intimate partner violence (IPV), reproductive coercion, and unintended pregnancy with women in unguarded settings (i.e., the women's homes) while providing ongoing services via a therapeutic relationship. Using individual interviews and a deliberative discussion focus group, the current study examined the research question, to what degree do home visiting staff members' personal and professional identities impact their ability to effectively screen and support pregnant women and new mothers around the topics of unintended pregnancy and intimate partner violence including reproductive coercion? Interviews and a deliberative discussion focus group were conducted virtually with staff members from Healthy Families America (HFA) programs in Maryland. Six major themes emerged from the interviews and focus group: personal versus professional experience, therapeutic alliance building, keeping families engaged, use of supervision, addressing intimate partner violence/reproductive coercion in families, and home visiting in the time of a health pandemic. Participants shared how their personal and professional identities helped shape their perceptions of their roles within the home visiting field including the terms, its meaning, and the

expectations of that role. The findings suggest that home visitors need additional training around reproductive health since they routinely interact with pregnant women and new mothers who are at-risk for poor pregnancy-related health outcomes that may be due to the lack of control or intention related to reproduction. Participants expressed general knowledge, comfort, safety plan creation, and resource linking around the issue of IPV. Participants had received extensive training on administering the Relationship Assessment Tool (RAT), which is the IPV screener for HFA. However, relatively few program recipients endorsed that their HFA program recipients are experiencing IPV using the RAT. Therefore, HFA staff would benefit from advanced level training utilizing more clinical skills around the topic of IPV including advanced screening skills.

The Interplay of Home Visitors' Personal and Professional Identities in Effectively
Screening and Supporting Women around Sensitive Topics

by

Karen M. Burruss-Cousins

Dissertation submitted to the Faculty of the Graduate School of the
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List of Abbreviations

ACE	Adverse Early Childhood Experiences
ACF	Administration for Children and Families
CDC	Centers for Disease Control and Prevention
COVID-19/COVID	2019 Novel Coronavirus; Severe Acute Respiratory Syndrome Coronavirus 2
DHHS	U.S. Department of Health and Human Services
EHS-HV	Early Head Start-Home Visiting
FRS	Family Resource Specialist
GGF	Growing Great Families
GGK	Growing Great Kids
HFA	Healthy Families America
HIPPY	Home Instruction for Parents of Preschool Youngsters
HRSA	Health Resources and Services Administration
IPV	Intimate Partner Violence
MCH	Maternal and Child Health Services Block Grant
MDH	Maryland Department of Health
MIECHV	Maternal, Infant, and Early Childhood Home Visiting program
NFP	Nurse-Family Partnership
PAT	Parents as Teachers
PPFA	Planned Parenthood Federation of America
RAT	Relationship Assessment Tool
RC	Reproductive Coercion

STI	Sexually transmitted infection
TC	Target child
WEB	Women's Experience with Battering Scale

Chapter 1: Introduction

Problem Statement and Background

Maternal and child health outcomes are a major focus of public health efforts in the United States and worldwide because mothers' and children's well-being determine the health of the next generation and can help predict future public health challenges for families, communities, and the health care system" (Office of Disease Prevention and Health Promotion, 2021, para. 2). Maternal and child health home visiting programs can improve outcomes as they cover a wide range of topics and domains related to child maltreatment, parent/child attachment, promotion of well child/well baby visits, promotion of health programs for families, addressing social aspects of child rearing, and community resources, making their interventions possibly quite comprehensive (Ammerman et al., 2010). Unfortunately, home visiting programs have also consistently been insufficient in addressing the issues of intimate partner violence (IPV), maternal mental health, and substance abuse (Tandon et al., 2005). Due to home visiting programs' large reach to over 150,000 children and parents within 27% of U.S. counties through federal funding, there is a substantial investment in home visiting as a prevention method (Health Resources and Services Administration [HRSA], 2021b). To increase the maternal and child health outcomes from home visiting programs, it is important to understand the factors that improve their service delivery methods (Ammerman et al., 2010). Home visiting programs are also unique in that they are "among the earliest portals through which sizable numbers of high-risk mothers come to the attention of service providers, thereby creating...opportunities to identify and intervene with mental health and other social needs" (Ammerman et al., 2010, p.192). Thus, home visitors are

in a distinct position to screen for, and address concerns related to unintended pregnancy and IPV including reproductive coercion.

Conducting virtual interviews and a deliberative discussion focus group, this dissertation will examine home visiting program staff's experiences related to screening and supporting women around sensitive topics. The research participants for this dissertation come from local Healthy Families America (HFA) home visiting programs across the state of Maryland. The current study explores home visitors' perspectives and experiences of utilizing screening techniques within high-risk populations. The dissertation accomplishes the following: (1) identifies factors associated with home visiting programs related to maternal and child health outcomes including screening techniques; (2) reviews current empirical studies on measures of maternal and child health outcomes and home visiting; (3) describes the methods used for this dissertation; (4) presents the results; and (5) discusses the results, study implications, and future directions.

Unintended Pregnancy. Pregnancy intention serves as a measure of reproductive health within a country, and unfortunately the United States is currently experiencing a public health problem where almost half of all pregnancies in the United States are unintended (Finer & Zolna, 2016). The US unintended percentage is greater than other regions in the world such as Africa, Asia, and Europe (Singh et al., 2010). Unintended pregnancy, according to the National Survey of Family Growth, is defined as a conception that is mistimed (i.e., pregnancy is desired eventually but not at this time) or unwanted (i.e., pregnancy is not desired now or in the future; Finer & Zolna, 2011). Unintended pregnancy is often a consequence of inconsistent and inaccurate

contraception usage (D'Angelo et al., 2007; Dalby et al., 2014), with women and girls living in poverty and those cohabiting at the highest risk for unintended pregnancy in the United States (Finer & Zolna, 2016). These at-risk groups are two to three times more likely to have an unintended pregnancy compared to the national rate (Finer & Zolna, 2016).

The phenomenon of unintended pregnancy is associated with a multitude of social and health-related negative consequences for both mothers and children. Pregnancy-related outcome measures generally associated with unintended pregnancy include lack of antenatal care (i.e., prenatal services), drug and alcohol use during pregnancy, perinatal mortality, perinatal morbidity, and low birth weight (Gipson et al., 2008; Pallitto et al., 2005). Women experiencing an unintended pregnancy are more likely to initiate antenatal care later in the pregnancy (Joyce et al., 2000; Korenman et al., 2002) and complete fewer visits (Kost & Lindberg, 2015) compared with woman experiencing an intended pregnancy. Delaying antenatal care can be problematic because this type of care helps to reduce morbidity and mortality for both the mother and baby during pregnancy by detecting and treating pregnancy-related issues while identifying those at risk for labor and delivery complications (Carroli et al., 2001). However, negative health outcomes (e.g., morbidity, mortality, low birth weight, etc.) within unintended pregnancy cases are mixed when controlling for physical and socioeconomic factors (Gipson et al., 2008; McCormick et al., 2011; Pallitto et al., 2005).

Additionally, studies have found a multitude of negative maternal reproductive health outcomes resulting from a pregnancy being unintended. Researchers have consistently found higher rates of abortion in pregnancies that were perceived as

unintended (Finer & Henshaw, 2006; Finer & Zolna, 2016; Upadhyay et al., 2012), as well as women who have repeat abortions being at risk for having an unintended pregnancy (Jones et al., 2006). Due to varying availability, affordability, and access to abortion and post abortion services, the maternal health risks from unsafe abortions can vary greatly including mortality, chronic infections, infertility, and risk to later pregnancies (Gipson et al., 2008). The major consequences of unprotected sex include an increased risk of an unintended pregnancy and/or the acquisition of a sexually transmitted infection (STI; Cates & Steiner, 2002). Social factors such as income and race/ethnicity also play a piece in unintended pregnancy. For example, women living in poverty are not only at an increased risk of experiencing an unintended pregnancy, but also of acquiring the human immunodeficiency virus (HIV; El-Sadr et al., 2010).

Unintended pregnancy has also been linked to several negative maternal mental health, child development, and maltreatment outcomes. Having an unintended pregnancy increases the likelihood that the mother will develop depression and anxiety (Cheng et al., 2009; Herd et al., 2016; Su, 2012). Unintended pregnancy has also been linked to IPV, where women who indicate their pregnancies were unintended at greater risk for physical violence (Pallitto et al., 2005). Conversely, the risk of having an unintended pregnancy is also increased in women experiencing IPV compared to those who do not identify as a survivor (Miller & Silverman, 2010). For the purposes of this study, IPV is defined as a wide range of behaviors such as rape, unwanted sexual contact, physical violence, stalking, reproductive and sexual control, economic abuse and psychological aggression like name calling from an intimate partner (Black et al., 2011). Various negative child outcomes including lower attachment security and child mental

proficiency (Bronte-Tinkew et al., 2009) and later child maltreatment (Guterman, 2015; Sidebotham et al., 2003) have also been associated with unintended pregnancy. To combat child maltreatment within the United States, home visiting programs have become the most widely used prevention approach (Alonso-Marsden et al., 2013).

Home Visiting. Home visiting, as a means of support and services to families in their homes, has been a part of human services in the United States since the 1800s (Finello, 2012). Home visiting is defined by the U.S. Health Resources and Services Administration (HRSA) as voluntary, evidence-based services within the home that are culturally appropriate, tailored to meet the individual needs of a family, and provide information on a range of topics including parenting, child development, health, and safety with referrals to support when needed for pregnant women and families with young children at risk for child maltreatment (2021b). Many of the services performed by traditional home visitors have moved into the realm of professionalization and managed care through Medicaid Home and Community-Based waiver services (Normile et al., 2017). Even though these professionals (e.g., social workers, teachers, therapists, nurses, etc.) at times do continue to work with the most vulnerable and high-risk populations in the home, there still exists a subset of paraprofessionals who continue to serve as guides and mentors on health and child rearing to pregnant women and new mothers in the home as well (Child & Family Research Partnership, 2015). These in-home providers keep the tradition of neighbors helping neighbors with the added benefit of evidence-based curricula, promising practices, new technologies, and a vision of positive short and long-term outcomes for the whole family unit. The current model of home visiting maintains

echoes of the past while integrating science, research, and a varied array of information delivery techniques (Department of Health and Human Services [DHHS], n.d.-a).

Hundreds of different home visiting programs exist across the United States with a wide variability in program structures and strategies (Johnson, 2009), but all programs hold common core elements. All programs utilize direct staff members to provide case management to mothers/parents and children along with psychoeducation training. In addition, all programs also include: (1) early engagement in a child's life prior to negative outcomes forming, (2) early engagement with mothers/parents to enforce positive parenting practices, (3) strengthening protective factors within the individual/family and mitigating child developmental risk factors, (4) use of multiple techniques to address child and family needs, (5) frequent communication and visits with families to deliver curricular components, and (6) staying involved with the family beyond initial birth to meet new needs of families and children as developmental transitions occur (Ammerman et al., 2010).

There has been a recent growth and expansion of home visiting programs across the United States resulting from the 2010 creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (HRSA, 2021b). MIECHV is administered by the Health Resources and Services Administration and the Administration for Children and Families (ACF) (HRSA, 2021b). Established by the Affordable Care Act, MIECHV was created within Title V of the Social Security Act's Maternal and Child Health Services Block Grant (MCH). The MCH grant has been in existence over 80 years since the creation of the Social Security Act in 1935 (HRSA, 2021b). Title V and the format of the MCH grant itself have gone through many different

versions over the years due to amendments, but the overall focus on using Federal-State partnerships to safeguard the health and safety of children and mothers has remained constant (Harwood et al., n.d.). More specifically, MCH and the MIECHV program are designed to serve families and communities at risk for negative health and educational outcomes through the coordination and implementation of comprehensive services, which strengthen the programs and activities under Title V (HRSA, 2021b).

To achieve the federal maternal and child health goals for these at-risk families, MIECHV encourages the use of evidence-based home visiting program models which have been shown to improve short- and long-term outcomes for at-risk mothers and children in the United States (HRSA, 2021b). In order to meet the evidence criteria, a home visiting model must have one of the following: “at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains;” or “at least two high- or moderate- quality impact studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain” (DHHS, 2021, p.15222). These results must be found across the full sample or replicated for the same domain across subgroups in two or more studies. If the study conducted is a randomized control trial only, then statistically significant impacts must hold true at least one year after enrollment and be reported in a peer-reviewed journal. If the study conducted is a single-case design, then additional requirements are called for including minimum number of combined cases and varying research teams across multiple institutions (DHHS, n.d.-b).

In addition to establishing MIECHV, the Affordable Care Act also set new benchmark requirements for home visiting programs receiving federal and state funds to report data on several home visiting measures. One of these benchmarks asks home visitation programs to report on measures tracking the reduction of domestic violence or crime (HRSA, 2021a). The benchmark requirements did not dictate what specific measures and assessments are to be used to document this reduction. Individual states and home visitation programs were given autonomy in selecting what they viewed as the most appropriate means of data collection for this federal requirement (HRSA, 2021a). Within the state of Maryland, programs with state and federal funding are mandated to report the percent of mothers/parents who improved their parenting behaviors and their parent-child relationship, the percent of mothers/parents experiencing domestic violence at 36 weeks of pregnancy, the percent of mothers/parents experiencing domestic violence post-delivery, the percent of mothers/parents experiencing domestic violence at program intake, and the percent of those mothers/parents reporting domestic violence who received safety planning within 24 hours of screening (Maryland Department of Health [MDH], 2017).

Intimate partner violence (IPV). There is a long-standing relationship between IPV and child abuse which has led to the requirement of home visiting programs to measure and report on findings related to those outcomes (Hazen et al., 2004). More specifically, parents who are victims of IPV, usually women, demonstrate less positive parenting skills, more physical aggression towards children, and more neglect of children than parents who do not experience IPV (Chiesa et al., 2018). If IPV is broadly defined as containing both physical and sexual violence, then the concept of reproductive coercion

also begins to emerge. Reproductive coercion (RC), a form of sexual violence, has been associated with unintended pregnancy and includes birth control sabotage, coercive behaviors to induce pregnancy, and control over the outcome of a pregnancy such as forcing a decision about whether to terminate a pregnancy (Miller et al., 2014).

Research has shown that for home visiting programs to be effective in creating a reduction in IPV, the program must include intervention techniques designed to decrease IPV incidents (Prosman et al., 2015). Home visiting programs are ideal places for IPV interventions because of their focus on families who have difficulty engaging in other services (Duggan et al., 2000) and the MIECHV requirement to document appropriate screening, referrals, and safety planning for those families indicating IPV in the home (Sharps et al., 2013). Despite home visiting's fit as a means of screening and providing services for IPV, very few intervention programs are specifically designed to be delivered within a home visiting method, while the majority of promising interventions are brochure/pamphlet based (Sharps et al., 2016).

Home Visiting and the COVID-19 Pandemic. As discussed above, one of the aims of home visiting is to achieve the federal maternal and child health goals for at risk families. Meeting these goals means addressing social determinant of health (e.g., low socioeconomic status, history of abuse, current or past experience with substance abuse or mental health issues, etc.) and minimizing childhood traumatic events known as Adverse Early Childhood Experiences (ACEs) by supporting families (McKelvey et al., 2016). Poorer health outcomes are disproportionately seen within disadvantaged groups when items like social determinants of health and ACEs are not addressed (Palmer et al., 2019).

During the Coronavirus outbreak, these disadvantaged group, such as those children and families targeted by home visiting programs, have been more severely impacted by the effects of the pandemic (Sharma et al., 2020). The need to stay at home due to the pandemic and economic downturn has led to an increase of violence in the home and disrupted the ability of home visitors to serve as in-home positive role model as well as models of parent-child attachment (Williams et al., 2021). Low-income parents have also reported being disproportionately worried about the pandemic and more likely to feel the effects such as unemployment, food scarcities, and family stressors (Hamel et al., 2020; Williams et al., 2021). As IPV and child abuse occur together in almost 30% of cases, the increase in IPV during the quarantine suggests that child abuse rates within the home are also increasing (Kaukinen, 2020).

Home visiting programs have responded to the national pandemic with necessary adaptations. These adaptations have included utilizing flexibility and national models for tele-home visiting to continue to deliver needed support to families, but just not in person (Williams et al., 2021). National home visiting programs, like Healthy Families America (HFA), have also created updated best practice standards to respond to the changing home visiting landscape resulting in social distancing and the need for virtual visits (HFA, 2020).

Gaps in the Literature. By using science, research, and adapted resource delivery procedures to augment the services provided by home visitors, a rich literature about home visiting has been produced to guide improvements. The various research studies within the literature have examined the benefits, costs, and outcomes of home visiting programming across the United States. However, much of the information reports mainly

on the participants in these home visiting programs, while there is a dearth of information about the staff and management that implement these programs. The data available on home visiting programs include demographic statistics about program recipients, first person experiences and impressions of being in the program, long and short-term child maltreatment outcomes, and so on. When attempting to locate basic information on program staff such as gender, age, race, and years of experience, the research literature is relatively silent. Exceptions do exist for some home visiting programs, namely those employing nurses such as Nurse-Family Partnership (Wasik & Roberts, 1994; Watson et al., 2016).

Not only is basic demographic information about home visiting program staff lacking in the research literature, but also discussions on successfully implementing screening procedures for home visitors around sensitive topics like IPV (Sharps et al., 2013). Universal screening for IPV among all women of child-bearing age accessing preventative health services has been a recommendation from the U.S. Preventive Services Task Force since 2013 due to literature indicating that universal screening can identify survivors, potentially increase safety, and can lead to improvements in clinical outcomes (Bair-Merritt et al., 2014; Chang et al., 2003; Moyer & Force, 2013). The acknowledgment of potential benefits of universal screening for women experiencing IPV, along with the federal requirement for MIECHV funded programs to collect data on IPV (HRSA, 2021a), means that home visitors may be able to meet their reporting requirements using universal screening techniques. Information about home visitors' experiences with implementing screening procedures of any kind are lacking in the

research literature with most studies focusing on the nurse home visiting populations (Sharps et al., 2013).

Some of the difficulties in acquiring data about home visitors are due in part to the settings these staff members work in. Within the state of Maryland, home visiting programs can be found within the Department of Education, the Department of Human Services, and the Department of Health (Maryland Governor's Office for Children, 2019). Funding for these programs comes from a variety of federal, state, local, and non-profit funds with most programs (60%) being a combination of all four. State funds are required to be used for evidence-based (75%) or promising practice (25%) home visiting programs. Within Maryland, the evidence-based models being used are Early Head Start, Healthy Families America, Home Instruction Program for Preschool Youngsters, Nurse-Family Partnership, and Parents as Teachers, but only Healthy Families America and Nurse-Family Partnership are being funded by block grants (MDH, 2017).

Study Purpose

The current exploratory study will focus on qualitative interviews and a deliberative discussion focus group with home visiting staff from one of the block grant funded programs, Healthy Families America, which utilizes non-nursing home visitors in the program. The literature has shown that home visiting programs with nurses as front-line workers (e.g., the Nurse-Family Partnership model) produce more positive significant effects on maternal and child health outcomes when compared to home visiting programs with paraprofessionals (Olds et al., 2014). Other studies have found similar differences between nurse and paraprofessional home visiting programs, but the effect sizes were small. One study examining program outcomes across maternal and

child health, child development, and reductions in child maltreatment domains, found that Nurse-Family Partnership programs had favorable effects in all five domains whereas Healthy Families America programs produced favorable effects in four domains (Avellar & Supplee, 2013). Most other home visiting programs examined produced one or two favorable effects within the domains except for Early Start which produced three favorable effects (Avellar & Supplee, 2013). Though Nurse-Family Partnership has shown more positive significant impacts for at risk families, Healthy Families America is not far behind.

The current study explores home visitors' perspectives on several factors related to unintended pregnancy, IPV including screening and referral, and home visiting programs and procedures that impact service delivery. Home visitors were asked about their personal and professional understanding of pregnancy intention in the high-risk populations they serve, their perceived comfort level and ability to ask sensitive questions like experiences of IPV and RC, their opinion of availability and quality of training designed to address sensitive questions, and the support received from supervisors around screening for and providing resources around sensitive topic areas like IPV. The focus on home visitors' personal and professional perspectives allows the researcher to examine how role identity influences home visitors' behaviors regarding the above-mentioned areas. The research question guiding the current study is, "To what degree do home visiting staff members' personal and professional identities impact their ability to effectively screen and support pregnant women and new mothers around the topics of unintended pregnancy and IPV including RC?"

In summary, the current study explores four main concepts through the lens of home visitors' identities, both professional and personal. These concepts include: (1) Unintended pregnancy: a conception that is mistimed (i.e., pregnancy is desired eventually but not at this time) or unwanted (i.e., pregnancy is not desired now or in the future; *Finer & Zolna, 2011*); (2) IPV: also known as domestic violence, dating violence, perinatal intimate partner violence, and sexual violence, includes a wide range of behaviors such as rape, unwanted sexual contact, physical violence, stalking, reproductive and sexual control, economic abuse, and psychological aggression like name calling from an intimate partner (*Black et al., 2011*); (3) Reproductive coercion: a collection of reproductive control behaviors related to manipulating pregnancy outcomes through force and/or coercion, referring only to heterosexual relationships with men perpetrating RC on female partners, consisting of pregnancy coercion, birth control/contraceptive sabotage, and controlling the outcome a pregnancy (*Miller et al., 2014*); and (4) Home visiting program: voluntary, evidence-based services within the home that are culturally-appropriate, tailored to meet the individual needs of a family, and provide information on a range of topics including parenting, child development, health, and safety with referrals to support when needed for pregnant women and families with young children at risk for child maltreatment (*HRSA, 2021c*).

The above-mentioned concepts are explored due to a variety of reasons. Unintended pregnancy is a national public health issue that impacts not only pregnant women but also their children. Unintended pregnancy is associated with a multitude of negative social and health outcomes for both the mother and the child including child maltreatment, IPV, and RC (*Guterman, 2015; Miller et al., 2014; Pallitto et al., 2005;*

Sidebotham et al., 2003). Home visiting programs are the most popular prevention model for child maltreatment (Alonso-Marsden et al., 2013), and with the creation of the MIECHV program in 2010, federally funded home visiting programs are required to report on IPV measures within program recipients (HRSA, 2021a). Home visiting programs therefore serve as an ideal location to deliver effective unintended pregnancy, IPV, and RC interventions.

Chapter 2: Literature Review

Introduction to Chapter

The current study draws from literature on home visiting programs, unintended pregnancy, IPV, and RC to demonstrate the connections among these concepts. This chapter describes home visiting programs and their role in supporting positive maternal and child outcomes. The current chapter also describes in greater detail the study's target home visiting program, Healthy Families America (HFA). Later in the chapter, information about the relationship between unintended pregnancy, IPV, and RC, including negative health and social outcomes for women and families experiencing these topics, will also be shared.

Home Visiting Programs

In the United States, the most widely used prevention method for child maltreatment is home visiting programs (Alonso-Marsden et al., 2013). Pregnant women and families participating in federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs are given resources and skills designed to help children become healthy from a physical, social, and emotional standpoint as well as ready to learn (HRSA, 2021c). MIECHV includes home visiting programs recognized by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF).

The home visiting programs under MIECHV are voluntary, evidence-based, and strive for three main goals. Those goals include preventing child maltreatment while improving maternal and child health, utilizing positive parenting approaches, and having a focus on school readiness and child development (HRSA, 2021c). As described in the

previous chapter, evidence-based is defined as having one of the following: (1) “at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains;” (2) “at least two high- or moderate- quality impact studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain” (DHHS, 2021, p.15222).

Home visiting programs are also designed to provide a multitude of services for families at risk for child maltreatment. The services under home visiting programs include prenatal and preventative health support, breastfeeding advice, parent education related to developmental milestones and behaviors in children, utilizing positive parenting techniques, and assisting mothers in planning for the future (e.g., continuing educational goals, gaining employment, and accessing childcare, etc.) (HRSA, 2021b). Home visiting programs vary greatly in terms of target populations, risk criteria for eligibility, curricula, content, and frequency of visits, but all programs believe that providing in-home services for high-risk families will result in positive long-term outcomes for children (Casillas et al., 2016). Appendix A provides an outline of the target populations and outcome domains achieved by the five evidence- based home visiting models used in Maryland.

Home visiting programs accomplish the goals of improving the health and welfare of families from pregnancy through early childhood using teaching, modeling, and community resources. National funding for home visiting programs is found in every state, several U.S. territories, and within Indian tribal organizations. Individual grantees are required to use 75% of the funds on evidence-based models; while the remainder of

the funding can be used for promising practices and programs that have not yet been evaluated (HRSA, 2021c).

Home visiting programs are a staple parenting intervention used for families at risk for child maltreatment (McFarlane et al., 2010). These programs have been modified and tailored to fit specific needs for the over 150,000 people served in FY 2017 among all 50 states, Washington D.C., and five territories (HRSA, 2021b). Home visiting programs have demonstrated positive child and family outcomes related to health and educational achievement (HRSA, 2021b). Twenty programs recognized by HRSA and ACF meet federal criteria for evidence based (MDH, 2017). Five of those evidence-based programs are utilized within Maryland, described in Appendix A, and include Early Head Start, Healthy Families America, Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership, and Parents as Teachers (MDH, 2017). Though these five programs can be found across the state, only two of the programs, Healthy Families America and Nurse-Family Partnership, receive block grant funding (MDH, 2017). These evidence-based home visiting models offer the protective factor of support during the stressful periods of pregnancy, birth, and postpartum by providing in-home visits, education, referral and screening, and community resource linkages (MDH, 2017).

Federal formula funding for MIECHV programs is awarded to every state with the Maryland Department of Health designated as the grantee in Maryland (HRSA, 2021c). Even though only two programs receive federal formula funding in Maryland, all programs receiving state or federal monies report on a set of standard measures. These measures include percent of well-child check-ups, mothers screened for and receiving mental health concerns, mothers' stress level, child developmental questions from the

Ages and Stages Questionnaire, children referred to special needs' programs, improved parenting practices, and IPV screening at a specified time interval with subsequent safety planning (MDH, 2017). For IPV screening, the measure is reported as “percent of women who were screened for IPV; percent of women who screened positive; and percent of positive screens who completed safety plans within 24 hours of the screening” (Maryland Governor’s Office for Children, 2019, p. 40). Even though these domains and standard measures are required, the timing of when programs collect the data varies greatly. For Fiscal Year 2019, of the 66 home visiting programs who responded to the state’s survey, only about half ($n=34$) screened for IPV. From those 34 home visiting programs, 95% of eligible women ($n=1,658$) were screened for IPV with 7% ($n=106$) screening positive. Safety planning was completed within 24 hours for about half (49%) of those women who screened positive (Maryland Governor’s Office for Children, 2019). Screenings were typically administered twice while the women were in the program, but the tools used to assess IPV varied within home visiting programs across Maryland. The 34 programs that screened for IPV used nine different screening tools, though the majority (51%) of the programs, including HFA, used the Relationship Assessment Tool (Maryland Governor’s Office for Children, 2019).

The quality of home visiting programs can vary due to numerous factors related specifically to the characteristics of program staff. Programs that ensure staff have formal training, promote a higher frequency and longer duration of visits, adequate compensation, and overall organizational support have been linked to high quality and favorable program outcomes (Thurman et al., 2014). The specific makeup of home visiting programs and their staff vary greatly regarding onset, duration, education and

experience of staff, intensity of services, types of screenings performed, and staff's ability to address barriers to IPV screening (Evanson, 2006). Due to fostering relationships between in home worker and high-risk pregnant women, home visiting programs are useful in identifying IPV and providing resources (Alhusen et al., 2015; Evanson, 2006). This suggests the need for consistent training and screening procedures to be implemented within those programs to promote universal screening for violence against pregnant women and new mothers (Alhusen et al., 2015; Evanson, 2006). However, there are mixed results as to whether home visiting programs are effective at reducing IPV (Duggan et al., 2004). When IPV is seen as more complex rather than a binary variable, and the issue of sexual violence, which RC falls under, is included in the study, results of the effectiveness of home visiting programs to promote change becomes more apparent (Bair-Merritt et al., 2014). Due to these mixed results, the Centers for Disease Control and Prevention (CDC) stated that there is a need to further replicate home visiting program studies to determine their effectiveness for reducing IPV (Bilukha et al., 2005). Recent studies do show participants in home visiting programs demonstrating statistically significant decreases in IPV victimization (Van Parys et al., 2014), but these studies are still few and need continued replication per CDC recommendations

Demographic makeup. Although demographic makeup is readily available for home visiting program recipients nationwide, typically limited information is available about the workforce in these programs. The most recent report from Fiscal Year 2019 on outcomes of home visiting programs in Maryland reported on several domains of workforce demographics, including adding gender identification, race/ethnicity, and age

range of home visitors (Maryland Governor's Office for Children, 2019). In the 2019 report, home visiting programs were asked to respond about their employee demographics for the 66 program sites; 71% of those sites were from HFA programs and there were 226 front-line home visiting staff. Most of the workforce had obtained Bachelor's Degrees (55%) or Graduate Degrees (24%). The home visiting workforce was almost exclusively female (98%) with most home visitors identifying as Black/African American (49%) or White (33%). Almost a third of home visitors identified as Latino/a (29%). The average age of home visitors was 37.5 ($SD=10.7$) and had spent a mean of 3 years ($M=3.1$, $SD=1.6$) as a home visitor. The median caseload size was 10.

Relationship of Intimate Partner Violence and Reproductive Coercion to Unintended Pregnancy

Intimate partner violence, also known as domestic violence, is a major public health concern in the United States and worldwide (Campbell, 2002; CDC, 2021a; Garcia-Moreno et al., 2005; World Health Organization, 2010). Intimate partner violence (IPV) includes a wide range of behaviors such as rape, unwanted sexual contact, physical violence, stalking, reproductive and sexual control, and psychological aggression like name calling (Black et al., 2011). Over one-third of women (35.6%) and over one-fourth of men (28.5%) have experienced IPV in the United States (Black et al., 2011). Female survivors of IPV experience a multitude of impacts because of the violence including fear or concern for safety (27%), symptoms of post-traumatic stress disorder (22.3%), and injury or a need for medical care (14.8%; Black et al., 2011). Survivors of these types of violence have more and longer hospital stays, visit healthcare providers more often, and have a host of health consequences when compared to those who have not experienced

violence (Black et al., 2011; Planned Parenthood Federation of America (PPFA), 2012). Additionally, female survivorship of IPV is connected to poorer sexual and reproductive health outcomes such as repeat abortions, increased risk of developing STIs, and an increased risk of unintended pregnancies when compared with women who have not experienced IPV (Jones & Finer, 2012; Miller & Silverman, 2010; Moore et al., 2010).

Emerging research has found a subset of reproductive control behaviors occurring within intimate relationships even when no other indicators of violence are identified (Miller, Jordan, et al., 2010). Prior to introduction of these reproductive control behaviors as a standalone phenomenon (Miller, Jordan, et al., 2010), previous research viewed those behaviors as only indicators of IPV (Black et al., 2011). This collection of reproductive control behaviors, related to manipulating pregnancy outcomes through force and/or coercion, will be referred to from this point as reproductive coercion (RC). For the purposes of this study, RC will refer only to heterosexual relationships with men perpetrating RC on female partners as reproductive intention and pregnancy resulting from heterosexual sex; both are key areas of interest for the current study.

The behaviors in RC include when one partner tries to control aspects of pregnancy attempts, timing, and outcomes in opposition to what the other partner wants (Miller, Jordan, et al., 2010). Reproductive coercion includes three main types of behaviors: (1) pregnancy coercion, (2) birth control/contraceptive sabotage, and (3) controlling the outcome of a pregnancy (Miller et al., 2014). Pregnancy coercion is used by males when a female partner does not want to become pregnant, and can include verbal pressure, physical threats, and/or other pregnancy promoting behaviors such as dictating when, if, and what type of birth control will be used (Miller, Jordan, et al., 2010;

2014; Nelson et al., 2012). Birth control/contraceptive sabotage refers to methods such as poking holes in condoms, throwing away birth control pills, and denying access to preferred birth control (Clark et al., 2014; Thiel de Bocanegra et al., 2010). Controlling the outcome of a pregnancy is defined as one partner establishing when to keep or terminate a pregnancy (Miller, Jordan, et al., 2010). Even though for the purposes of this study, RC only refers to male behaviors on females, it is important to note that about 8.6% of women and 10.4% of men in the United States have reported being recipients of RC, even though they may not have identified themselves as being in an abusive relationship (Black et al., 2011). However, RC is a unique risk for women because it can result in unintended pregnancy (Gee et al., 2009).

Women experiencing RC, and human service workers assisting them, may not readily identify symptomatic behaviors related to RC due to the many terms used for the same concept. In addition to the terms used above (i.e., pregnancy coercion, birth control/contraceptive sabotage), RC has also been referred to as male reproductive control (Moore et al., 2010). Additionally, women experiencing RC may have fallen under the category of unintended pregnancy. Studies have shown that RC is one of the mechanisms linking IPV and sexual violence with unintended pregnancy (Black et al., 2011; Gazmararian et al., 2000; Miller & Silverman, 2010; PPFA, 2012; Zachor et al., 2018).

When a woman is pregnant and experiences violence during her pregnancy, there is also a greater risk of poor health outcomes for both the new mothers and their babies (Campbell, 2002). Between 3.9% and 8.3% of women report abuse in pregnancy, and poor health outcomes include miscarriage, stillbirth, low maternal weight gain, and low

birth weight (Campbell, 2002; Dube et al., 2005; Gazmararian et al., 1996). However, these outcomes are mediated by the mothers' response to stress from the abuse (Campbell, 2002; Curry & Harvey, 1998; Sarkar, 2008). Preterm and low birth weight babies may have ongoing health conditions that put them at a greater risk for mortality and chronic health/developmental problems (Behrman et al., 2007). These health conditions, even if only temporary, can lead to greater financial and emotional stress in caregivers after birth as compared to before birth (Singer et al., 1999). Home visiting programs address some of these negative health outcomes resulting from IPV as a part of their core program goals. Home visiting programs can provide prenatal and preventative health support which would help mitigate some of the poor birth outcomes (HRSA, 2021c). Thus, home visiting programs are the ideal intervention vehicle for not just IPV, but RC as well.

Chapter 3: Theoretical Underpinnings

Introduction

The current study examines concepts which uniquely impact women when compared to men. Women experience unintended pregnancy differently than men as women are the ones physically developing and nurturing the child in-utero throughout the duration of the pregnancy. Women, as the primary recipients of intimate partner violence and reproductive coercion, also experience these issues differently than men who are generally seen as the perpetrators of violence against women (Alderson et al., 2013; Black et al., 2011; Dobash & Dobash, 1979; Walker, 1979). Home visiting programs strive to address many health and social issues; most of those issues relate to improving maternal and child outcomes as mothers and children are the main focus of the home visiting services (HRSA, 2021a).

Despite the plethora of research on violence against women and reproductive control spanning the last couple of decades and across a multitude of disciplines, there is little agreement about common theoretical perspectives guiding studies around women's issues. Feminist theory, though, has been the most widely used theory to describe violence against women (McPhail et al., 2007). One central concept within feminist thinking to evolve over the past few decades has been that of intersectionality, which acknowledges relations among social identities including overlapping oppressions (Crenshaw, 1991; Shields, 2008). Within the context of violence against women, intersectionality helps to shed light on how the impact of violence is shaped by women's other identities such as race and class (Crenshaw, 1991). The notion of interactions of multiple identities within oneself can further be crystalized using Identity Theory which

states that society shapes social behavior, every individual has multiple social identities, and depending on a situational context, some identities are invoked more than others (Stets & Burke, 2014). Additionally, in the terms of the helping relationship, those multiple identities are a part of the therapeutic alliance between the home visitor and the client. The Theory of Therapeutic Alliance states that there needs to be a person who wants a change and then another person who serves as a change agent (Bordin, 1979). For the purposes of this study, it was hypothesized that the therapeutic alliance between the home visitor and client is a social construct that is co-created by the interactants to make meaning of an interaction. That social construct also includes the multiple identities that the home visitor (i.e., change agent) and client bring while existing in a world of violence against women where social identities like overlapping oppressions make some women experience violence differently than others.

Elements of feminism, intersectionality, Identity Theory, and the Theory of Therapeutic Alliance will be used as a theoretical foundation within the current study. See Appendix B for visual representation of how the theories relate. These theories will be used to understand the following research question: To what degree do home visiting staff members' personal and professional identities impact their ability to effectively screen and support pregnant women and new mothers around the topics of unintended pregnancy and intimate partner violence including reproductive coercion?

Feminist Framework

Within the violence against women research literature, feminist theory has most frequently been used to understand the concept because of its discussions of male oppression of women resulting from a patriarchal system as the explanation for violence

against women (McPhail et al., 2007). Feminist theory also states that men are the predominate perpetrators and women are the victims (Dobash & Dobash, 1979; Walker, 1979). While this view of gender roles is an oversimplification of Feminist Theory in general, a true discussion of feminism would not be complete without discussing the history of the women's movement and the resulting types of feminism produced.

Mainstream feminism has been defined as advocating for equal political, social, economic, and civil rights for women and men (Krolokke & Sorensen, 2006). The first wave of feminism from the late 19th/early 20th century dealt with women's access to rights and equal opportunities such as entering the workforce and the right to vote (Krolokke & Sorensen, 2006). The second wave of feminism arose out of the civil rights movement of the 1960s and 1970s and the women's empowerment movement of the 1980s and 1990s (Krolokke & Sorensen, 2006). Several societal shifts led to the creation of the large scale feminist movement during the start of the second wave of feminism including: (1) women's entrance into the workforce during World War II and their subsequent encouragement to leave the workforce once the men returned home from war; (2) post-war prosperity in the west which led young people to question the capitalist methods leading to this prosperity for some and poverty for others due to various forms of inequality; and (3) rebelliousness of youth and their subsequent questioning of society, along with the introduction of alternative life-styles and viewpoints which allowed the women's movement to gain a foothold in a world with criticism of established social norms and optimism of what the future could hold (Friedman et al., 1987).

Feminism has generally been designated into four main types, each with their own unique approach to addressing gender-based inequality. These types include liberal,

radical, Marxist, and social feminism. Liberal feminists view equality for women as being able to have the same opportunities within the professional field, political sphere, and labor market as men (Friedman et al., 1987). From a liberal feminist perspective women have the same capacity to make decisions about their lives that men do, but due to societal discrimination against women, those choices are constrained. To combat discrimination, liberal feminists believe there should be a level playing field within the current capitalist structure enforced by non-discriminatory laws (Eagly & Wood, 2011; Friedman et al., 1987)

Radical feminists feel that liberal feminists do not go far enough in making changes, while also noting that little attention is paid from liberal feminists on reproductive freedom (Friedman et al., 1987). For radical feminists, seeking the root cause of oppression against women, and then addressing how the oppression of women is the source of all other oppressions, serve as the guiding principles. Within radical feminism, the goal is to combat patriarchy and social oppression through the understanding that the personal is political, meaning that the oppression and dominance found in personal relationships with men are part of the larger societal and political structure putting men in power. This viewpoint sees the rearing of children and duties assigned to those actions as something that should be addressed in society and not just within the family unit where women are relegated to the role of caregiver (Friedman et al., 1987). Radical feminists also argue for reproductive rights including the right to choose methods of contraception and make choices about pregnancy outcomes. To achieve liberation and equality, radical feminists advocate the creation of women only spaces in the public, private, and workforce spheres and the dismantling of the patriarchy

by eliminating traditional gender roles and reconstructing concepts of gender within society (Friedman et al., 1987; Tuttle, 1986).

Marxist feminism views women's plight more in relation to women's involvement with the workforce rather than in their existence as women. Marxist feminism believes that the way to liberate women is through work in a socialist system where the exploitive practices of capitalism could be shed, and when technology, workforce developmental progress, and social relations change in a way to benefit the working class (Friedman et al., 1987). Whereas classical Marxism did not view women as facing differing forms of oppression when compared to men, expanded work by Engels (1902) acknowledged women's inferior position in the home and saw work outside of the home as a means of escaping and establishing economic independence.

Social feminism was formed in an effort to address women's role not just in the work force, but also to confront the additional gender-based inequality experienced by women when compared to men (Friedman et al., 1987). Social feminists agree with Marxist feminists that liberation can be achieved by moving away from the capitalist model, but technological and developmental advances also need to be applied beyond the workforce sphere to procreation and sexual work, such as through the development of birth control methods. Additionally, social and Marxist feminists both agree that work production freedom can be found when the workforce is not exploited by capitalism, but social feminists also believe women need to be free in the sexual and procreative spheres as well. This sexual and procreative freedom means no sexual coercion, rape, or sexual harassment. Social feminists are against sexual division of labor based on biology because the differences between men and women are a social construct and can be altered

(Friedman et al., 1987; Jagger, 1983.). Liberation is also viewed as a social achievement and must occur within the private and public spheres, but to achieve these ends class and patriarchy must be combated to end exploitation of women and male dominance over women (Dietz, 2002; Friedman et al., 1987).

Though each of the above-mentioned types of feminism view the path to women's liberation differently, they all agree that women experience oppression differently from men. The causes of this oppression and the impact to women vary, but all forms of feminism agree that to make changes in women's lives, political changes must be made first. The previously discussed types of feminism demonstrate growth and change across the feminism framework but fail to fully explore the interlocking systems of power and oppression experienced by marginalized groups of women (Crenshaw, 1989). In response, the analytic framework of intersectionality was presented to feminists by Kimberlé Crenshaw as a means of understanding how the interactions between oppressions (i.e., being Black and being a woman) reinforce societal oppression (Crenshaw, 1991).

Intersectionality

Even though initial feminist scholars focused exclusively on gender as the unit of analysis, newer work from feminists focusing on historically marginalized groups during second wave feminism expanded the view of feminism and intimate partner violence to now examine the intersections of other forms of oppression such as race, class, and sexual orientation (Collins, 2000). Through Crenshaw's seminal work, the concept of overlapping and intersecting oppressions (i.e., intersectionality) was presented for the first time within the context of feminism. Crenshaw's work also discussed the vastly

different experiences women of color have because of their multiple identities and multiple oppressions when compared to White women who were typically seen as the face of the feminist movement (Crenshaw, 1989).

To demonstrate the impact of intersectionality, Crenshaw (1989) presented the example of how women of color experience violence against women, including intimate partner violence and rape, differently from White women. Black women have worn a range of labels from sexually immoral jezebels, hot mommas, insatiable women incapable of being raped because they are always willing to engage in sexual activity, all the way to matronly mammy (Collins, 2000; Mowatt et al., 2013). These labels originated with the use of Black women as sexual objects by White male slave owners for both profit and pleasure (Collins, 2000). Unfortunately, these themes of racist and sexist ideologies are seen frequently to this day and are so commonplace they are seen as almost natural or inevitable in our society (Collins, 2004). Black women attempted to fight these images in the late 1800s/early 1900s by creating politics of respectability that governed the way Black women acted such as promoting temperance, cleanliness, and sexual purity (Hine, 1989; Mowatt et al., 2013). Unfortunately, those politics only helped to reproduce the dichotomous view of hypersexual or asexual Black women (Hine, 1989; Mowatt et al., 2013).

Beyond highlighting the differences in lived experiences among women with multiple marginalized identities, Crenshaw (1991) outlined several aspects of intersectionality which impact the visibility of women of color. These aspects of intersectionality include structural, political, and representational. Structural intersectionality identifies how a person's social needs are marginalized (Shields, 2008).

Political intersectionality addresses the varying needs and goals of the individual's groups (Shields, 2008). Representational intersectionality deals with identity construction through a cultural lens (Crenshaw, 1991). These aspects of intersectionality demonstrate how within an individual there are a multitude of identities constructed through cultural and group identification. As intersectionality points out, an individual is not able to control the societal impression of these identities. However, when viewed through Identity Theory, the influence of situational context can describe why some identities come to the foreground while others are not invoked in a particular set of circumstances (Stets & Burke, 2014).

Identity Theory

Identity theory, similar to feminism and intersectionality, is influenced by social structure and socially defined roles (Stets & Burke, 2000). According to this theory, people act within the confines of the social structure to assign themselves and others into roles which then inform meaning and expectations around the assigned roles (Stryker, 1980). An individual's identity is then formed in terms of that role, its meaning, and the expectations associated with that role, which in turn inform standards which guide behavior (Burke, 1991; Burke & Tully, 1977). Those identities then strive to control resources (i.e., items that sustain people and their interactions) through meaningful activity within a particular role, in essence the definition of social structure (Burke, 1997; Stets & Burke, 2000).

Identity theory further states that people use feedback from others and from their own internal reflections to understand their behaviors within a given situation. Subsequently, people modify their behaviors to make the meaning of the interaction

match their identity. Behavior itself is not important, but instead the meaning which is subject to change based on social confirmation. An individual can then verify that the meaning of a situation has changed in the desired way based on other people's responses. Identity verification is therefore a match between situational meaning and one's identity standard. When there is a mismatch, the individual feels an emotional reaction like distress and attempts to modify their behavior to correct the situation (Stets & Burke, 2014). Leadership studies testing this concept demonstrated that when the level of leadership behavior slipped below a leader's identity, the leader increased his or her leadership behavior in subsequent discussions thus demonstrating an inverse relationship between behavior and identity (Burke, 2006).

The current study used this concept and its inverse relationship to inform the degree to which home visiting staff members' personal and professional identities impacted their ability to effectively screen and support pregnant women and new mothers around the topics of unintended pregnancy and intimate partner violence including reproductive coercion. By examining times when home visitors felt distress talking with their families about unintended pregnancy, intimate partner violence, and reproductive coercion, the researcher explored what behaviors the home visitors used to elevate these emotional reactions. Generally home visitors pulled from personal and professional experiences to respond to sensitive topics. By examining responses across multiple home visitors, the researcher looked for similarities and differences which indicated that the home visitors' behaviors were related to their professional training and experience, as well as their personal identities interacting with an at-risk family.

Theory of Therapeutic Alliance

During the research process, another theory, the Theory of Therapeutic Alliance, emerged to provide assistance in answering the research question. Like Identify Theory, the Theory of Therapeutic Alliance is a social construct that is co-created to make meaning of an interaction. For the purposes of the current study, the Theory of Therapeutic Alliance refers to the work of Bordin (1979) where he states that the working alliance is “between the person who seeks change and the one who offers to be a change agent is one of the keys, if not the key, to the change process” (p. 252, paragraph 4). Bordin goes on to state that the working alliance can be found in a number of different relationships besides therapist and client such as student-teacher relationship, or any place where there is a person who wants to change and another person who will be the change agent. Bordin (1979) also further defined the therapeutic working alliance as consisting of three components: mutual agreement on the definition of the therapeutic goals; accord on the individual tasks that establish therapy; and the connection between the consumer and therapist. For this study, the therapeutic relationship focused on the participant and home visitor. Either party in this alliance could strive for social desirability in their goals and tasks. If that occurs, one could hypothesize that the individual feels distress and attempts to modify behavior due to conflicts with identity as previously discussed (Stets & Burke, 2014). Building a therapeutic alliance emerged as a theme within the data where study participants discussed ways in which they created the therapeutic alliance with their families, which will be discussed in later chapters.

Chapter 4: Method

Researcher Role

Before describing the methods of the study, it is important to explain the orientation and philosophical approach the researcher is using within the current study. Through the use of qualitative research, Maxwell (2012) suggests that researchers need to examine their personal, practical, and intellectual/scholarly goals in reference to why a study is started. This researcher came into her doctoral program with several years working in the domestic and sexual violence prevention realm and had an additional interest in sexual development including healthy sexuality and pregnancy intention. Throughout the course of the researcher's doctoral work, she has continued to focus on these content areas. While in the doctoral program, the researcher also gave birth to her two children with 20 months between births. The timing and planning of these pregnancies was intentional and a mutually agreed decision beforehand for both the researcher and her husband. The researcher chose to utilize contraception to delay her pregnancies until a time period where she felt financially and emotionally ready to handle the role of motherhood. The act of making this decision in her life led the researcher to reflect on her experience compared to what other women may experience in their lives. This reflection brought new light to the researcher about the experiences, emotions, trials, and tribulations pregnant women, new mothers, and those service providers working with them may experience while navigating unhealthy intimate relationships. Further research led her to look more closely at the concept of reproductive coercion and its association with unplanned pregnancies and intimate partner violence.

Through examination of reproductive coercion and unplanned pregnancy literature, the researcher began to ponder her theoretical leanings. Reproductive coercion research has shown that women experience this phenomenon even without identifying any other forms of intimate partner violence, thus lending support to reproductive coercion's existence as a standalone concept. Reproductive coercion also potentially provided a partial explanation for reasons behind unplanned pregnancy (Miller et al., 2014). Due to the researcher's own feminist leanings, she began to wonder how feminist theory might be combined with other theoretical perspectives to shed light on women's roles and thoughts during pregnancy and their relationships with their intimate partners. The researcher's tendency to gravitate towards qualitative methods also added a dimension to how she viewed data gathering with a constructivist and feminist lens.

As a new mother coming from a middle-class background with family support, the researcher also thought about the resources available to new mothers and pregnant women who did not have the same background and access to assets as the researcher. Through the researcher's exposure to reproductive coercion literature, she learned about the "Healthy Moms, Happy Babies" curriculum from Futures Without Violence which addressed many of the researcher's topic areas. This curriculum, designed for home visitors, demonstrated efforts by an anti-violence against women organization to utilize universal screening, co-constructed safety planning, and resource discussion within the intimate setting of a home visit. The researcher was intrigued because home visiting programs reminded her of her previous sexual health work with a local health department which used community embedded extension offices in public housing areas to provide better services to community members. The researcher viewed community health

personnel as key to accessing hard to reach populations experiencing disproportionate amounts of unplanned pregnancies and violence, such as violence against women, in the community. Thus, the events and experiences described above led to the development of the current study, which is to examine how home visitors' approach to screening and intervening with the program recipients related to unplanned pregnancy, intimate partner violence, and reproductive coercion.

Due to the personal and professional associations the researcher has had with the subject matter and considering the researcher's use of self as a data analysis instrument, a discussion of the various steps the researcher used to reduce bias is necessary. First, the researcher made memo notes directly after interviews if something struck her such as a particular impression from the interview or further questions that might come up during the next interview (Maxwell, 2012). The researcher also added to those memos during the transcription phase. These memos allowed the researcher to regularly self-reflect about the research process, her role in that process, and how the process is ensuring that the subject matter expertise of the participants is being captured (Maxwell, 2012). The researcher also utilized a member of her dissertation committee to do an occasional peer-debriefing to continually analyze the researcher's assumptions about the data, the research participants, and expectations of the research process. The peer-debriefing was used to ensure credibility, or believability of the data (Houghton et al., 2013). The peer-debriefer was familiar with home visiting around the state of Maryland and had proficiency in public health and social work skill sets. The peer-debrief sessions consisted of discussions of potential views of bias and check-ins about data labels and the logic taken to arrive at those labels (Graneheim & Lundman, 2004).

Research Design

The current study used qualitative interviews and a deliberative discussion focus group with home visiting staff members and supervisors with a grounded theory framework. Grounded theory is a type of methodology used within qualitative studies to construct theory through systematically collected and analyzed data (Glaser & Strauss, 1967; Strauss & Corbin, 1994). Grounded theory was used to develop the research design, sample selection, procedures, and coding. The other theories, such as Feminist and Identity, were used to interpret the data results and explain themes. For research design, several unique features exist within grounded theory including simultaneous data collection and analysis, categories and codes formed from the data itself and not through pre-existing conceptualizations, theoretical sampling to further define categories, inductive construction of categories, use of memos during the coding and writing process, and categories assembled into a theoretical framework (Charmaz, 2014).

The use of grounded theory as a research design also means the acknowledgement of theoretical sensitivity. Theoretical sensitivity is the insight of the researcher into the meaning behind the data (Glaser, 1978). The researcher is tasked with understanding what the data is trying to say including separating out relevant from non-relevant parts. Using theoretical sensitivity brought about by in depth reading of the phenomena of study, personal and professional experience, and the analytic process of data collection and processing, the researcher can develop a dense and cohesive theory grounded in the data (Glaser, 1978; Strauss & Corbin, 1990).

Sample Selection

The use of a qualitative study design, along with a grounded theory approach, means that a purposeful/purposive sampling design was appropriate (Corbin & Strauss, 2008; Maxwell, 2012; Patton, 2002). Using this type of sampling strategy allowed the researcher to select participants that have detailed knowledge and experience with the topic of interest, as well as an availability and eagerness to participate in the study. The study participants reflected on their ability to effectively screen and support new and expectant parents regarding factors related to child maltreatment as well as supporting fellow co-workers during dramatic program changes due to the pandemic. These selected participants articulated their experiences and opinions in an expressive and reflective manner giving information richness to explore the study's concepts and overall purpose of research (Palinkas et al., 2015; Patton, 2002).

The target home visiting program for the current study was Healthy Families America. This home visiting program was selected because it is one of the two programs in the state of Maryland receiving MIECHV funding, which means the program is required to report on benchmarks associated with intimate partner violence. Healthy Families America was also selected due to its use of paraprofessionals as program staff members and little is known about how home visiting paraprofessionals implement screening procedures (Sharps et al., 2016).

Healthy Families America (HFA), created in 1992 by Prevent Child Abuse America, is designed for families during the prenatal period or within three months of birth with services offered until at least the child's third birthday, preferably the child's fifth birthday (HFA, n.d.). The HFA program is theoretically grounded in positive

parenting, attachment, strengths-based, and family centered practices. HFA was designed specifically for parents with challenges that reflect social determinants of health like low income, history of abuse, and current or previous experiences with sensitive topics like substance abuse, mental health issues, and/or intimate partner violence (HFA, n.d.). The types of services offered by HFA include screening and assessments related to risk of child maltreatment and other adverse childhood experiences, weekly one-hour visits during the first six months after birth with continued visits based on family need, routine child development and maternal depression screenings, and individual locality services like support groups (DHHS, 2020). Staff members of the Healthy Families America program are also required to have training around core issues. These core issues include trauma-informed practice, parent-child attachment principles and how to work with parents to implement those principles, and reflective strategies to support parents so the parents will feel competent and empowered to make positive changes (DHHS, 2020). The issues of IPV and RC are related to maternal well-being and health which can impact all core issues but specifically trauma-informed practice. Therefore, IPV and RC are not core issues themselves in the field of home visiting but addressing IPV and RC can support the core issues.

The purposeful/purposive sampling design was broken down further into criterion and snowballing strategies throughout the study. Initially the researcher used a criterion based strategy to locate individuals who met the following predetermined important criteria for the study: (1) a woman as the core concepts of the study impact women differently than men, (2) a staff member in a program using the Healthy Families America curriculum currently in the community, (3) a staff member who currently

implements the Healthy Families America curriculum with pregnant women or new mothers OR a staff member who currently supervises a staff member or members who implement the Healthy Families America curriculum with pregnant women or new mothers. The researcher asked participants, once they completed the study and if participants were willing, to share the researcher's contact information with their fellow co-workers through a snowball strategy so the participants could identify others with similar characteristics desired in the study.

The researcher started her sample selection pool by working with the Maryland Department of Health (MDH) to identify those programs receiving MIECHV funding and using the HFA program. The researcher went through the MDH Internal Review Board (IRB) and received approval to recruit from local departments of health with a MIECHV funded HFA program. Non-health department programs, such as non-profits, receiving MDH MIECHV fundings did not require the MDH IRB approval for participation in the study, but the researcher still referenced the MDH IRB approval when contacting those programs to demonstrate legitimacy.

The researcher started her recruitment process by reaching out to the MDH funded HFA program managers in rural localities. The initial targeted communities in the study were rural because women within rural settings have shown an increased risk of experiencing higher rates of intimate partner violence with greater frequency and severity of physical forms of abuse as compared with women in urban settings (Peek-Asa et al., 2011). Thus, home visitors within these communities may have been more likely to have interacted with a program recipient needing IPV services and more willing to discuss experiences of screening and providing services to these women. Rural localities were the

first approached for the study with urban and near urban localities approached next. Unfortunately, none of the four urban and near urban areas approached for inclusion in this study participated (two declined due to participation in other research, one did not respond to any inquires, and one did not follow up with researcher after initial information exchange).

Procedures

The current study used primary data collection from in-depth virtual interviews and a virtual deliberative discussion focus group conducted with management from HFA programs in Maryland, as well as using field notes and memos from the researcher. Interviews, though not in person, allowed the researcher to study the participants' and researcher's social interactions, individual and multiple identities, and interpretations of meanings (Blumer, 1969). The deliberative discussion focus group design allowed member checking with Healthy Families America management while also contributing new research data.

Study participants were asked to participate in interviews or the focus group to explore their understanding, perception, and experience of asking sensitive questions to their program recipients and/or their experience supporting fellow co-workers asking sensitive questions to families. Sensitive questions in the home visiting literature usually refer to family trauma which can include family violence, mental health concerns, and substance use (National Home Visiting Resource Center, 2017). Research participants were encouraged to explore what had worked and what had not worked when approaching sensitive topics with program recipients. The researcher also probed

specifically about intimate partner violence, reproductive coercion, and pregnancy intention.

To begin the interviews, participants were asked about their own backgrounds and experiences as a means of starting the conversation with a minimally emotionally charged topic (see Appendix F for the complete interview guide). Next, broad open-ended questions were asked to elicit a story from the participant and allow them to talk about their problem-solving process. The interview guide was developed with the assistance of the peer de-briefer and three doctoral level researchers to evaluate the reliability of the interview questions (i.e., were the questions clear and reflective of the study design; Miles et al., 2014). Mock interviews were conducted with the doctoral level researchers to also determine question ordering to ensure a conversation tone. The doctoral level researchers included: (1) a researcher who had expertise in early childhood development including impacts of home visiting on child health outcomes; (2) a researcher who had expertise in using interviews and creating interview guides as a primary research data collection tool; and (3) a researcher who had experience with qualitative methods and previous research in home visiting.

The opening question on the interview guide asked participants to describe their experiences with the HFA program including thoughts about the program's philosophy and program structure. The opening line of questioning allowed the participants to reflect more on their own experiences and backgrounds, keep their professional expertise at the forefront of the conversation, and allow them to be eased into the conversation. The participants potentially demonstrated a social desirability bias, where they attempted to find answers that they believed were more socially desirable rather than what was

reflective of how they truly felt (Nederhof, 1985). To minimize that type of bias, the researcher focused her probes on the specifics of the HFA program including the role of parenting styles, populations the programs serve, etc. to capture what the participant viewed as the reality of the program and not what they hoped the researcher wanted to hear.

Once the conversation had started and the participant hopefully began to feel more at ease, the research delved into more programmatic questions followed by home visitors' work experiences. The second interview question asked about the types of screeners collected by the HFA, which were standardized across all programs resulting in the researcher omitting this question as a main question after five interviews as all HFA programs use the same screeners. Instead, the researcher used the types of screeners collected as a probing question when asking about participants' experiences asking sensitive questions. Interviewees were then asked about a typical day, a successful case, a difficult case, a case where the home visitor had to ask and/or handle a sensitive topic, formal and informal supervision and mentoring processes, and what sort of training opportunities the worker has had including training for sensitive topics.

The deliberative discussion focus group was held with HFA management staff who had not previously participated in the interviews (see Appendix G for the complete focus group guide). The focus group offered an opportunity for the researcher to do member checking with participants who had the same required training as interviewees and served in HFA programs. Four out of the five focus group participants had also been home visitors themselves, so they had dual role knowledge as supervisors directly supporting home visitors and peers who had also been in the field working directly with

families. The focus group also offered the researcher the ability to double check whether interview participants had supplied socially desirable answers as the focus group participants had the dual role knowledge to evaluate interview responses. The focus group participants said the interview responses presented to them were accurate and based on real experiences, not reflecting socially desirable answers.

Focus group participants, in keeping with the deliberative decision model, were provided a written summary of the interview findings prior to the start of the focus group (Rothwell et al., 2016). By providing the finding ahead of time, the focus group participants could provide more informed opinions thus resulting in more quality data (Rothwell et al., 2016). The focus group allowed the researcher the opportunity to fill in gaps in information based on the data analysis and ensured that initial themes were being captured and conceptualized according to the interview participants' meanings. The focus group was used to gather new information, as well as a type of validation technique through member checking to ensure the researcher accurately captured the meaning of interview participant quotes as proposed by other studies (Birt et al., 2016; Klinger 2005).

The focus group included four participants, but another individual, a program manager, had wanted to be a part of the focus group but was unable to attend. Therefore, a one-on-one interview was conducted with this final participant but the focus group information and question sharing (i.e., focus group question guide and sharing the results of the interview) was used. The focus group guide started by verbally discussing the results, a copy of which had been emailed to each participant prior to the start of the focus group. The focus group participants were asked if the results were expected, true to their program, and missing anything. Clarifying procedural questions that arose out of

the interviews, such as annual training hours requirement, were asked. Participants were also asked to personally reflect on what a typical day was like now including engagement of their supervisee staff in a virtual format.

Logistics for the current study were changed just prior to the start of data collection due to face-to-face restrictions from the COVID-19 pandemic. Initially the researcher was going to collect data in person, including consent forms. However, shortly before obtaining MDH IRB approval, which occurred after IRB approval from the University of Maryland, Baltimore, the university restricted face-to-face research resulting in the researcher submitting a modification for all virtual interaction with participants to both MDH and University of Maryland, Baltimore IRBs. The all-virtual format included a waiver of written consent approved by the university and all interviews/the focus group had to be conducted over the preferred virtual platform for the university, Webex. Each interview lasted about 60 minutes and the focus group was slightly longer at 80 minutes. Each participant was emailed a copy of the consent form prior to any recordings. Participants were also given an opportunity at the start of each recording to ask questions about the study prior to giving consent. Participants decided the timings of the interviews to ensure their participation and to honor their time, as active participant involvement is key to interview research (Padgett, 2008). All participants received monetary compensation of \$25 for their participation in either the interview or the focus group as a thank you for the participants' time and efforts. Monetary compensation was a virtual gift card sent using the university approved Rewards Genius format. HFA program staff who were also health department employees were able to receive the gift card due to approval from the MDH IRB.

Sample Demographics

A total of 11 interviews and one deliberative discussion focus group with five participants was completed. One of focus group participants was unable to attend the scheduled date of the + discussion focus group but still wanted to participate so she could reflect on the results of the study. The researcher used the focus group questions in a one-on-one virtual meeting with the program manager who missed the focus group.

Demographic information about the interview participants can be found in Appendix C and focus group demographics are in Appendix D. Additionally, in Appendix E the pseudonyms for each participant, along with some demographic information, can be found. Four counties/localities were represented in the data including Dorchester County, Frederick County, Mid-Shore area, and Washington County. Interview participants came from all four of these localities and focus group participants came from two of these localities. The Mid-Shore area was served by one HFA program where staff could work with families in the following counties: Caroline, Kent, Queen Anne, and Talbot. Two of the four communities in the study, Washington and Dorchester counties, were identified by MDH as some of the state's highest need areas regarding maternal and child interventions (MDH, 2017). Those highest need communities, Washington and Dorchester counties, were also considered at-risk rural localities based on population size and density, poverty levels, lack of adequate health care, lack of transportation, and geographic isolation (Hall-Sanchez, 2016; Rural Maryland Council, n.d.).

Sample demographics can further be broken down into differences found between the participants in the interviews and the deliberative discussion focus group which served as a means of member checking information discovered in interviews, as well as

adding new information to research data. All participants in the study were female, which is not unusual considering reported data on Maryland home visitors across the state showed that 98% are female (Maryland Governor's Office for Children, 2019). Focus group participants ($n=5$) were exclusively managers and supervisors of HFA programs. On average, focus group participants were older than interviewees (44.6 years old vs. 38.3 years old), had more experience in home visiting (113.4 months versus 57.4 months), had been in their current home visiting role longer (50.6 months versus 40.8 months), had been a primary caretaker for a child (100% versus 55%), and had more formal education with some or completed master's level education (60% versus 18%). Both interview and focus group participants had over half of the members identifying as African American/Black (60% for focus group and 55% for interview). Only the interview participants included someone not just identifying as African American/Black or Caucasian/White with one participant identifying as Caucasian/White/Hispanic. The researcher was unable to compare the variables of marital status and whether participant had ever lived in the locality they serve because of missing data from the focus group participants.

Data Analysis

Consistent with a grounded theory approach, data analysis techniques were integrated into the data collection process. From a practical standpoint, this integration meant that as data was collected, the transcription process began immediately allowing the researcher to discover if there were any data driven themes and areas that needed to be explored in greater depth (Charmaz, 2006). For the current study, there were no areas discovered from the data that needed to be explored in greater depth with changes in the

interview questions. The data analysis process was multistage across the entire study with multiple cycles of data gathering and data analysis (Oktay, 2012). The early stages of data analysis used open coding process to identify substantive (i.e., codes that follow the actual wording of the data) and theoretical codes (i.e., codes grounded in the data but reflected the researcher's lens, not the actual wording of the data) to help bring about the focus of the study by narrowing the scope. Early data analysis stayed close to the actual words in the data itself, while later analysis became more focused and abstract (Oktay, 2012).

Early Data Analysis. Once an interview had been concluded, the researcher started the data analysis process by listening to the interview and jotting down initial impressions, thoughts, and questions with an initial memo. The Webex software, the virtual platform for the interviews, did an initial automated transcript that the researcher finalized by listening to the interview while following along with the transcript to make corrections. After the transcript was finalized, the researcher did line by line open coding. During open coding the researcher looked for both substantive and theoretical codes. Substantive codes were those codes that most closely followed the actual words and ideas presented from the interviewee (Oktay, 2012). When a code was a word or set of words from the data itself, then the substantive code was referred to as an “in vivo” code, though some substantive codes did not mirror the text in the data. Theoretical codes did not directly come from the data and were instead a result of the researcher's prevailing paradigm and conceptual background, but the codes were still grounded in the data from the participants (Oktay, 2012). The researcher was cautious about the use of theoretical codes as those codes may steer the data analysis away from the actual wording in the

transcripts and into preexisting categories held within the researcher (Oktay, 2012). The researcher strived to use substantive codes as much as possible and labeled each initial code during open coding as either substantive or theoretical.

The researcher used Oktay's (2012) tips for open coding through the beginning coding phases to impart as much rigor as possible in the process. Oktay recommends coding all data line by line even when particular parts of the data may seem insignificant. Through having an open mind and scrutinizing all data, the researcher was less likely to miss key ideas needed which might have otherwise been seen as tangential. The researcher also attempted to do the initial open coding quickly to avoid lingering over particular passages or statements that she may have wanted to apply an abstract theoretical thinking to (Oktay, 2012).

Oktay (2012) makes several additional suggestions for identifying which type of words or passages from the data should be coded. Oktay recommends that during the open coding phase, researchers should be paying attention to capturing word data that discusses or creates strong emotions, describes actions, and reflect underlying assumptions (e.g., everyone does that, I never, it's always been that way, etc.). Oktay goes on to state that the researcher should also identify text that "reflects symbolic interaction concepts, such as sense of self, expectations of social roles, assessment of the judgements of others, and justifications for actions" (2012, p. 56). Researchers should also avoid applying a diagnostic label to the data, such as coding a series of feelings reported by a participant as "depression" when those words were never spoken (Oktay, 2012). Instead, the researcher needs to stay close to the actual word data and how the participant described their experience and feelings. For the current study, the researcher

used the following step by step procedure: (1) open coding where in vivo codes were highlighted in the text; (2) substantive and theoretical codes were clearly labeled by their type; (3) appropriate substantive codes were gerunds and active verbs; (4) reflections of symbolic interaction concepts were coded; and (5) memos were kept when ideas emerged about codes too complex for simple open coding (Oktay, 2012).

Within the early data analysis, open coding consisted of two steps. Those two steps were the development of initial codes via an open reading of the transcripts, and then subsequent grouping of those codes into categories, often called axial coding (Okay, 2012). The codes developed during the open coding stage were grouped into categories with all groupings of codes remaining categories in the early part of the study until specific patterns in the data began to emerge with the introduction of new participants and subsequent interviews. Once patterns emerged, categories were further developed into temporary themes with the final themes emerging once all data had been collected. As the researcher collected new data, she explored the dimensions and properties of the grouped codes (Oktay, 2012). Throughout the entire coding process, the researcher used constant comparative analysis to determine the relationship between the codes and categories. The relationship between levels of data was explored to see if they were related to one another, and if so, then how and why (Corbin & Strauss, 2008). The axial coding process (or second step of open coding) also allowed the data to be reassembled to “give coherence to the emerging analysis” (Charmaz, 2006, p.60). See Table 5 for a breakdown of categories into the final themes.

Ideally the constant comparison process would have continued in the synthetization step to assist with theoretical sampling (Oktay, 2012). The researcher

attempted to apply theoretical sampling to locate later rounds of participants for interviews as the data analysis revealed no voice was given to urban areas of the state. The researcher approached four HFA programs in urban and near urban areas to fill in the theoretical gaps in the data. However, of the four programs approached that would have met that gap, two declined because of their commitment to other research projects, one did not respond to inquiries, and one said they would have to check with HFA national but did not respond to follow up inquiries. Targeting urban HFA programs will be something the researcher can focus on in future research to expand the theory building process.

Throughout the early-stage data analysis, the researcher continued to use memo writing and peer-debriefing as a means of creating and sustaining credibility and validity within the study. Memo writing in that phase captured early ideas gleaned from the data in relation to characteristics of codes (i.e., substantive or theoretical) and combination of codes into categories. The researcher met with the designated peer-debriefer (see previous Researcher Role section) a total of three times over the course of the study. The first meeting was after the first four interviews were completed to discuss the experiences and challenges. The researcher and peer-debriefer met two more times to discuss categories derived from the codes and ideas for emerging themes in an effort to explore researcher biases and preconceived notions of the data.

Late-Stage Data Analysis. Late-stage data analysis did not have a clear-cut demarcation from early-stage data analysis, but instead was a natural process bridged by axial coding. As previously discussed, axial coding consists of the following components: “(1) identifying the variety of conditions, actions/interactions, and consequences

associated with a category; (2) relating a category to its subcategories; and (3) looking for clues in the data about how major categories might relate to each other” (Oktay, 2012, p. 74). Glaser noted that there were “6 C’s” which the researcher needed to question during axial coding: cause, context, conditions, consequences, contingencies, and covariance (Glaser, 1978). Oktay recommended adding two more types of questions: process (sequences of actions) and structural (under what conditions) (2012). Using these guidelines, the researcher strove to focus on developing the relationship amongst the categories in the data to create the final themes (see Appendix H for a listing of categories and themes).

Unfortunately, the researcher was unable to fully complete the late-stage data analysis steps called on by Oktay (2012) due to lack of available participants. Coding of the data at this stage focused on how categories related to emerging themes. Completion of this stage of analysis would require that the relationship of categories to themes would have been informed by the theoretical sampling design for the next round of data and paying special attention to levels/dimensions and range of properties within the categories. The researcher, the peer-debriefer, and the committee chair all felt that data saturation had been reached with the 11 interviews collected even though theoretical sampling within urban HFA programs was not completed. Saturation meant that no new information about the core categories was seen in the data (Oktay, 2012). Therefore, theoretical sampling and initial theory testing were not completed. Instead, the study focus turned more to theory generating by answering the following research question: to what degree do home visiting staff members’ personal and professional identities impact their ability to effectively screen and support pregnant women and new mothers around

the topics of unintended pregnancy and IPV including RC? The researcher felt that presenting the data in a way that answered the research question was more impactful as a start to theory building than speculating about what was missing from the theoretical sampling and theory testing. Negative case analysis, another piece of the grounded theory process, was also not performed. Negative case analysis is where the researcher would examine a case that does not fit with the hypothesis being formed to allow the researcher to better describe the limitations and conditions of the theory (Okta, 2012). In future studies, the researcher will strive to fill in the gaps in the data with theoretical sampling, negative case analysis, and theory testing.

Use of Deliberative Discussion Focus Group Data. During late-stage data analysis, the researcher chose to present the emerging themes from the home visitors' interview data to the focus group participants, who were home visiting managers, to determine whether the researcher was interpreting the data correctly. As previously mentioned, four out of five of the focus group participants had themselves been home visitors working directly with families, so they were able to offer perspectives of a manager and a home visitor. The focus group participants informed the researcher that yes, here interpretation of the data was accurate to the experiences of home visitors. The researcher also asked focus group participants whether there was any information missing, and focus group participants responded that no, nothing was missing.

Overall, the focus group participants felt that the researcher properly captured the meanings behind the responses from interview participants. The focus group participants did not bring up any new ideas that were drastically different from the data themes they were presented from the interviews. Instead, the focus group participants' statements

added depth and different angles to the presented themes. Therefore, the researcher decided to weave the statements derived from the focus group and interviews together in the findings to enrich the existing themes. This combined presentation showed how the home visitors (interviews) and home visiting managers (focus group) viewed the same issues, but from different perspectives. For example, the interview participants were able to speak to how helpful supervision with their managers had been to navigate questions and stressors from being a home visitor. The focus group participants were able to talk about the increased stress they are seeing in their supervisees, home visitors, during COVID and how some of the procedural questions presented to them by home visitors were outside of their control. The focus group participants also talked about the personal characteristics a home visitor needed to have in order to do the job successfully based on the experiences the focus group participants had as managers and home visitors themselves.

Chapter 5: Results

Introduction

The interviews and focus group for the current research study were conducted to answer the question to what degree do home visiting staff members' personal and professional identities impact their ability to effectively screen and support pregnant women and new mothers around the topics of unintended pregnancy and intimate partner violence including reproductive coercion? The data collection resulted in six major themes: (1) personal versus professional experience, (2) therapeutic alliance building, (3) keeping families engaged, (4) use of supervision, (5) addressing intimate partner violence/reproductive coercion in families, and (6) home visiting in the time of a health pandemic. These themes can be understood as summaries touching on the participants' experiences in broadly defined areas. The themes reported in this study are not mutually exclusive and do overlap with one another. However, the quotes have been grouped into themes based on which theme resonated best with the participant's intention for the quote. All real participant names have been omitted and only pseudonyms have been used to identify them to maintain anonymity. Home visitors who are labeled Dual Role Specialist performed the duties of a Family Resource Specialist, who does initial intakes with families, and Family Support Specialist, who carries the ongoing case load of families and does the routine home visits. Intake included administering the parent survey to program recipients which consisted of the initial packet of screeners including home safety, IPV, substance use, depression, etc. Some participants also called themselves Family Support Workers which is an alternative title for Family Support Specialist. If a

worker called themselves a Family Support Worker, then the labels for their quote reflect that language.

Personal versus Professional Experience

The theme of Personal versus Professional Experience arose out of the data when participants discussed where they gain knowledge from in order to respond to situations with their program recipients. Overall, participants talked about how a mixture of the personal and professional experiences in their lives led to their decision to do home visiting as a career, but also assisted them in connecting with their program recipients. This blend of personal and professional can be seen from Tamara, a Family Support Specialist, who used her personal experience as a mother to start building the relationships with program recipient mothers as well as sharing resources around the topic of breastfeeding. If a new mother said she was breastfeeding then Tamara said she responds by saying “yeah, I was a breastfeeding mom, you know, and we have resources to help you with that.” Another example of personal experience informing professional practice comes from a quote from Anne, a supervisor with the HFA program, who talked about where she draws her understanding and expertise from regarding responding to trauma reported by program recipients.

For me, I think it has to do with the fact that I have been trained. I have, I've been in human services, my whole career since I was 20 years old. I did some sort of human services and with all of the populations that I've worked with, I've worked with people with disabilities and work with senior citizens. I've worked, now working with families. There's always some kind of like some trauma or some things that people will tell you about. So, I think for me, it's just it's been part of

my training. And part of what I've just always known I wanted to do is help people, be there for people. So, but when you are in that moment, and they share something so deep and personal, you, I mean for me, I just have to really keep my emotions in check. Tell them I'm so sorry, that's happened to you and just give them that space. (Anne, HFA supervisor)

Responding to trauma from families was a common occurrence for the program recipients due to the nature of home visiting and the target population enrolled in HFA. Home visitors routinely screen and monitor for child maltreatment, IPV, ACEs, etc. One home visitor, Shawna, talked about responding to a program recipient's ambivalence regarding whether to terminate her pregnancy. Shawna utilized her personal experience with friends who had been in similar situations to empathize and support her.

And, like, I came in and she was like, [Ms. Shawna], I don't know if I want to keep this baby. I don't want to be a mom. I never wanted to be a mom. She was prenatal, I got her from the beginning. And, like, every day, she's like, I don't know if I want to keep this baby, you know. And I told her, I was like, I've been in situations where I've met people, I said I had friends, that gave up their baby, that gave up their rights, that had an abortion. So, I understand. I was like, I don't know what I would do in your situation. You know, but that's what I'm here for. We can talk it out, we can hash it out. (Shawna, Family Support Specialist)

Another home visitor, Megan, talked about how when she first started her job, she had a mother who was experiencing domestic violence. Megan's response to this trauma was to initially pull from her own experiences. Megan later reflected how she has learned

new techniques over her eight years in the job that she believed better suited her program recipients.

Eight years ago, I had a teenager who was in a domestic situation. And it was very hard for me because I would always joke that I'll just hit him back, you know. I just was the type that you lay hands on me, you're going to get hands laid back and there's not going to be a, you know, just, just not going to tolerate it. And over the years, I've learned that I can't do that. So now I do more of the understanding and putting myself in another perspective, and getting as much resources, like CASA or the hotlines for mom to try to get out of the situation.... With my teenage mother I had a daughter, my own, same age, and I just couldn't imagine being the parent, knowing that the boy was laying hands on my child. So that was I guess I, that's pretty much all that. You really have to put yourself, you have to put your beliefs aside. And start working through it that way. (Megan, Family Support Worker)

Participants shared about their motivations and knowledge base for working with not only families in the home visiting program, but also about the larger community. Participants discussed how their familiarity with the physical community they serve can be an asset. Eleven out of 12 participants noted that they either currently or had lived in the community that they now work in. Leslie, a Family Support Worker for less than a year, talked about how her personal, professional, and community knowledge helped her with her job. This quote from Leslie also demonstrates the overlap amongst themes, in this instance the overlap between Use of Supervision and Personal versus Professional Experience.

I think with my age and experience, like, I have done work early on in my 20s working with people. And my mom was very educated in that field. So, I think that helped the foundation for me. The training was good, but I don't think you really understand it until you are able to use it. And then you get in that situation where you're like oh, like, what do I do? And it's my, my supervisors have been more than supportive for me, because I usually get off the phone and call them right away. And I'm like, did I do this right? Is there something else I need to do? I'm very proactive anyway, so if I don't know something I'm going to ask, and I don't know if that comes with age or just my personality cause that's kind of just how I've always been. So, if I have a question, yeah, I'm going to kind of just ask. And knowing the resources in the area and being here for all my life, it really helped. Because I already know about some of them resources like CASA and been familiar with them from my own personal experience and how that kind of benefited me as a worker. (Leslie, Family Support Worker)

Therapeutic Alliance Building

Each participant was asked about their experiences working either directly with HFA program recipients or the home visitors who work with those program recipients. The HFA program is voluntary so participants found that many parents were interested in learning what they could from the program. However, participants were also very clear that good rapport had to be established early in relationships with families to have home visitors be a welcome presence in the home, regardless of how much a family was interested in the program. The participants talked about how they built that connection or relationship with their families through conversations and mutually agreed upon goals

and tasks. Natalie, a Dual Role Specialist, highlighted that just engaging in a regular conversation was effective in building the relationship.

And we'll just, it just gradually goes into a regular conversation, because I feel like I've built a relationship with all my moms. So, our, everything is really like a one-on-one conversation. It's like, I don't know how to describe it, it's just a good relationship where we're just talking. (Natalie, Dual Role Specialist)

Other participants talked about not putting expectations on their families, or meeting people where there are, as their basic clinical approach. For Bernadette, a Family Support Specialist, this meant “you have to meet people where they are and accept people for who they are.” Similarly, Kellie, a Dual Role Specialist, talked about keeping the goal in mind and working with the curriculum in the HFA program when meeting people at their starting point: “We try to meet people where they are, just see what we can do to help, you know, with the curriculum and then other things that are not necessarily with the curriculum to make them feel comfortable.” For Susan, a Family Support Specialist, not putting expectations on families for her was that “you have to put your beliefs aside and start working through it that way.”

As mentioned above, the curricula used in the HFA program played a large part in the daily work of the home visitors, but also served as a tool to build relationships and set goals. The curricula used included the Growing Great Kids (GGK) and Growing Great Families (GGF) created by Great Kids, Inc. (n.d.). Tamara, a Family Support Specialist, noted that for her, the curriculum offers an opportunity to ask personal questions in a way that demonstrates her willingness to learn about her families, not make mistakes due to ignorance, and builds her bond with the family.

Well, the curriculum, the GGF curriculum, they have a module that talks about, like, family and tradition. And it asks questions, like, you know, what does your family do for this? What does your family do for this? Talk to me about your culture or whatever. And I noticed that when I ask them questions like that and show interest, it kind of opens up that, that, that communication and then that bond because I'm showing interest in getting to know, you know, their culture, and not trying to be ignorant, that type of thing. (Tamara, Family Support Specialist)

Utilizing the curriculum and their rapport building skills, some participants, like Margot, were able to co-construct visit goals with the families while remaining true to the HFA program. In the following quote, Margot was referencing a relationship building technique she used with parents when they have things weighing on their minds. The beginning of the quote from Margot discusses how important it is that she follow through with any activities or resources she had promised a family.

Just following through, just following through and again, like, yes, we are going to talk about the curriculum today and I want to get to it. These are the important highlights, but obviously today you need to talk about you. Let's find a different module. Let's talk about toxic stress. Let's talk about postpartum depression. Let's talk about what you need. I'll find it. We'll discuss it. This part is about you, you know. (Margot, Dual Role Specialist)

As mentioned in the previous theme, there are overlaps amongst the research themes in participant responses. Participants demonstrating Therapeutic Alliance Building showed a lot of creativity and flexibility which was key in the Keeping Families

Engaged theme. Lucia, a Dual Role Specialist, talked about her Family Resource Specialist job duties which included administering the parent survey. Lucia learned that building that therapeutic alliance was the key to getting parents comfortable enough to answer the parent survey, so she started breaking up her intake visits into two different meetings with program introduction in the first visit and parent survey in the second.

You know if she wants to learn about services that will benefit her baby, and then from there she says oh yeah, I would love to learn about that, then I schedule another phone call for that, following week, and that's when I do the whole evaluation parents survey. And then, with that one she's a little bit more comfortable at that point, because she remembers, you know, our initial phone call so it's not that, that one's not too difficult for her to open up and talk about things. And I know that I personally do that, and the other family resource specialist here does it. And I kind of learned from her and kind of made it kind of work on my own. So, I feel like it's a good way to do it and not, you know that first phone call, you know, all of these personal questions. Talking to me for the first time I feel like that's a little bit too invasive, and you know let's not do that, let's space it out between. (Lucia, Dual Role Specialist)

Ruth, a Program Manager who was asked focus group questions, also stated something similar to Lucia's statements about first building a relationship before asking invasive questions. The following quote specifically referred to when Ruth's team administered the Relationship Assessment Tool which is their IPV screener.

They do the initial one within the first, um, the first, four weeks, three to four weeks, you know, kind of build that relationship first, before you start doing all

these screenings because you got to get to know ‘em, you know what I mean? So, we'll do one at, like, the third or four[th] visits. (Ruth, Program Manager)

During the deliberative discussion focus group with the HFA management staff, participants brought up additional factors that may impact the relationship building process with program recipients. One supervisor discussed how home visitors' personal trauma histories and the mandated virtual home visiting format could play a part in creating that therapeutic alliance. These personal experiences and virtual visits because of the pandemic, within the context of Therapeutic Alliance Building, are additional examples of overlap amongst the research themes.

The impact of stress home visitors [are] experiencing on their ability to build relationships, it's something that we've seen a lot during COVID. The current stress, and then also kind of the overlap of past experiences and being triggered, or re-traumatized by things that are going on within the home. Um, that's something that, I think impacts relationship building. (Linda, Clinical Supervisor)

Another focus group participant, Kathryn, a Program Manager, also felt that specific personal characteristics were needed to not only do the job of home visiting, but to also build a therapeutic bond.

You absolutely have to just be sort of generally interested in how people work, and how communities work, and what might be possible. Um, and kind of a general sense of hopefulness as an attitude towards the world. And also, some emotional sturdiness, like, you need folks who are empathetic, but not going to fall apart. You don't want them to match the emotional tenor of a family in distress. You want them to be able to be sort of emotionally sturdy and maintain

their balance even when things are kind of chaotic with the families that they're working with. (Kathryn, Program Manager)

Keeping Families Engaged

Participants often talked about how they were able to use their own ingenuity and independence to come up with ideas for engaging with their families. Participants also talked about how engagement was even more important during virtual visits than face-to-face contacts to keep families interested in the program and actively growing as parents. As previously mentioned, the themes in this study do overlap with one another, and virtual visits was a concept found in Keeping Families Engaged as well as the theme Home Visiting in the Time of a Health Pandemic. However, the theme Keeping Families Engaged also showcased various unique engagement techniques including personalization to meet individual families' needs, flexibility, and tokens of appreciation. One example Margot, a Dual Role Specialist, provided showed how she not only actively listened to her parents but also devised a way to reinforce HFA program lessons. In this example Margot is talking about items she included in her drop off package for the family, program materials and resources dropped off at the parent's home while maintaining social distancing, as they were meeting virtually.

Like, oh, your daughter was, during the last visit, you said she, you couldn't find your spoon. So, there's a spoon and fork set in the bag and, you know, it's the Minnie Mouse one we had in stock, and I just searched for it, threw it in your bag for you. And that's what you talked about the last visit, so here you go. So, it kind of, you know, drawing on just our talks and drawing on what we're talking about and where the child's at, or what their concern was that

last visit. I think that's helping to strengthen rapport, a little more than we used to you know. We used to just this is the activity, and we built that rapport through conversations and one-on-one does that. So now it takes more work. But I feel like if you're really individualizing what you are showing them or giving them, it's helping. (Margot, Dual Role Specialist)

Some home visitors also talked about different items or activities they were doing to demonstrate to families that the participation in the program is appreciated and could continue to be fun even if they were not meeting in person. Kellie, a Dual Role Specialist, talked about certificates and notes she gave her families to not only tell them she was thinking about them but also appreciated that they were sticking with the program.

I've even printed out certificates for perfect attendance or little thank you cards or thank you notes just to let them know that I'm thinking about them, that I appreciate them. You know things that kind of keep them encouraged and want to continue to meet with me. (Kellie, Dual Role Specialist)

Another participant, Susan, talked about how her program is creating new activities based on current seasons and holidays to keep families engaged. In Susan's program, they were able to get bulk seasonal craft items like foam picture frames for relatively little cost per program family and families were excited to do the activities with their children.

But I think the activities based on the seasons and based on like what we're doing, or where we're at, have really helped everybody and let them know that we're still thinking of them and that we're still trying this and we're going to keep on keeping

on and we, thank them for hanging with us and sticking with us and we're here, you know. (Susan, Family Support Specialist)

Participants also stressed flexibility along with the personalization of services for families, especially during the pandemic, to keep the families engaged. Once again, there is overlap amongst themes, in this instance Keeping Families Engaged and Home Visiting in the Time of a Health Pandemic. Not only were home visitors experiencing stress from the pandemic, but they also acknowledged that their families were stressed. Therefore, many workers made sure they checked in with families about stress and anxiety on a regular basis. Below is an example of this check in from Shawna.

But I've changed how I did my visits a little bit to kind of focus on and just check in with them to see how things are going first, you know, with them, with the family. My first 30 minutes is about that, just making sure that they're good first and not so much been gung-ho on the CHEERS [HFA screening assessment], the curriculum, you know, being so strict. I try to, you know, show them that they care, that I care and that I appreciate them still being a part of that program. That I understand. (Shawna, Family Support Specialist)

During the focus group, the management staff talked about how the ability to engage with a family was a personality trait needed by the individual home visitor to be successful in the job. Some focus group participants talked about how certain aspects of personality were necessary to not only work with the families, but to also have effective impacts in meeting program goals as outlined in the following quote by Linda, a Clinical Supervisor.

There are some people who have that energy or whatever it is to engage with people. The ability to engage and just have a natural curiosity about them, a natural curiosity without that judgmental piece. And then that, um, you know, just kind of that wonderment, uh, which really kind of gives us the energy to keep going in the field to do what we need to do with, with their families. But, um, that ability to engage and I haven't seen people be able to engage well, without just being curious. Kind of opens up your, your mind to wonder and you know, have conversations. And I think to be successful especially with the population that we're serving, and I would say it is not the easiest population. We serve people who've been you know, they have all kinds of issues and they've been burned and, and not very trusting of agencies and people anyway. So, the ability to actually engage people and somehow, maybe with your energy, tone of voice, whatever it might be, but to be successful, you have to have that, you know. Everyone who engages with these families they, it just, the job is much harder to do if you cannot really engage. (Linda, Clinic Supervisor)

Use of Supervision

The theme of Use of Supervision came out of the data as participants talked about their experiences working with their supervisors, informal mentoring amongst same job level co-workers, and even participants' own perceptions of the supervision process. All non-supervisory participants in this study had positive things to say about supervision and found something beneficial during supervision time. The same participants also talked about how their supervisors were always available to answer questions and provide

guidance, even if the method of availability (i.e., virtual meeting versus in person) had recently changed.

Supervision time, as discussed by non-supervisory participants, was a time of reflection about difficulties with a case as well as personal difficulties in life. Oftentimes participants talked about how they used what they learned in supervision (stress relieving techniques, non-judgmental reflection, etc.) to model with their families.

And I find that most of my supervisions have more of a reflection component, because I'm like, oh, my God, I'm so stressed out. It's good. It's a reminder that to speak with our families and to update, you know, check in with them because it is important, and this pandemic is crazy. (Bernadette, Family Support Specialist)

An example of a participant using supervision as a time to unload emotional baggage, including frustrations with a program family, can be found in this quote by Tamara, a Family Support Specialist. Tamara said she handles the feelings and her reactions from working with families mostly with her supervisor.

Especially sometimes I'll just go in her office and I'm like, I just need to vent sometimes, and she'll say yeah, go for it. So, I think mostly my supervisor and I think knowing that, like, I'm doing enough, like, sometimes I always feel like I could be doing more. But just kind of recognizing that I'm doing my part in what I'm doing is enough. (Tamara, Family Support Specialist)

For others, supervision is also a place of learning. Leslie, a Family Support Worker, discussed a case where she was dealing with a new mom experiencing physical

violence. Leslie stated she learned by “more understanding. I think it was more supervision, talking through it.”

The clinical supervision offered by HFA required a few workers to adjust their perceptions of supervision. Below is a quote from Natalie who had retail experience coming into the program, so did not fully understand the role of clinical supervision.

Supervision is good because initially, when I first started and it said supervision weekly, I'm like what? But it's a different kind of supervision. My supervisor asked me, you know, what am I doing to take care of myself? How have things been going for me this week, you know, and we kind of get to vent and then we go on to talk about our families. Or sometimes we just do a reflective thing. How are things going for you, you know? What families are you having difficulties [with]? It's like, how can I help you? Instead of me, instead of like, a real supervision, not real supervision, but the space, instead of how the average person would think you're not doing this, you need to do this, that type of thing. (Natalie, Dual Role Specialist)

For Megan, the adjustment to clinical supervision mostly just meant tolerating the job expectation to have supervision. Megan does state that she finds some benefit from meeting for supervision, but it is not her favorite thing.

I think it's long. An hour and a half to 2 hours. I think it's too long. I understand it's supposed to be like a self-reflecting. They're supposed to do a lot of reflecting on, you. Sometimes I feel I do get that reflection and sometimes I don't. I do like, the only thing I really do like about supervision is I can go in and talk about if

[there is] something I need like a second opinion. You know did I handle that right or should I have handled it a different way? That's probably really the only thing I like about supervision. (Megan, Family Support Worker)

Ruth, a Program Manager, pointed out that supervision is always something that is talked about when home visitors and management are asked about their jobs because there is no clear format for supervision.

Supervision is always a big one. Supervision is always something talked about because it wasn't really, it's like, they don't have a blueprint of how that, how it's done. So, everybody does it kind of differently and everybody accepted or don't accept it differently. (Ruth, Program Manager)

Participants also discussed relying on fellow home visitors for informal mentoring as well as formal supervisors to ask questions and receive emotional support. For Bernadette, a Family Support Specialist who had been in the field a little over a year, she found herself relying on formal (i.e., clinical supervision) and informal (i.e., talking with co-workers) modes of support close to equally.

I would probably say it's like, 60/40, mostly my supervisor, but my co-workers too. Because, I mean, like I said, they've all been there for such a long time. So, they have a lot more experience than I do. So, I'm sure they, I mean, like, if I have a quick question that I know that I can get answers from them, I probably will reach out to them. (Bernadette, Family Support Specialist)

For Natalie, a Dual Role Specialist, her view of this informal supervision was akin to having another meeting.

Normally after teams [staff meeting] we'll do like a group message where we'll text each other and then have a meeting after the teams. But it's not something, we might do scheduling, just randomly somebody will text something... sometimes we do have a meeting after the meeting with just some of us to where we talk. Or when we were in the office together like, the ones that work in my county, we would kind of vent to each other during work hours. (Natalie, Dual Role Specialist)

Addressing Intimate Partner Violence/Reproductive Coercion in Families

One of the reasons Healthy Families America was selected as the target home visiting program for the current study was because they routinely do IPV screenings. Therefore, workers are provided trainings in IPV and related resources as they are expected to address the results of the screenings with the families, usually the mothers in the families. The exact times of screening administration, though, vary due to program recipient answers and the requirements of the individual HFA program. Additionally, during the Parent Survey Assessment, pregnant women and new moms are asked about their feelings related to the current pregnancy. Thus, that question gives screeners (Family Resource Specialists) and later home visitors (Family Support Specialists/Workers) the opportunity to talk about pregnancy intention.

The IPV screening tool, called the Relationship Assessment Tool (RAT), is administered initially early on during the families' participation in the program and then again at least annually. The RAT is a 10-item questionnaire that is administered during the Parent Survey Assessment visits which usually occur around the first home visit once a family has been accepted into the program. This assessment visit is typically completed

with the Family Resource Specialist. The RAT, originally known as the Women's Experience with Battering (WEB) Scale, asks women about emotional abuse, vulnerability to danger, and loss of power and control using a 6-point response scale, 1 (Disagree Strongly) to 6 (Agree Strongly) (Smith et al., 1995). Home visitors are encouraged to administer the RAT in person, though HFA standards have changed due to in-home visitation restrictions from COVID-19. Home visitors are trained to administer the RAT during a conversation instead of a question-and-answer session. Anne, a supervisor, talks more about the expectations of providing the RAT and the other screenings in the Parent Survey Assessment, noting that some home visitors are uncomfortable talking about difficult topics with their program recipients.

When we ask the questions, we're trained to do it in a way, that's not like asking questions. It's trained to be more of a conversation. So, we don't, we typically don't start out saying, well, how is your childhood because they're going to be like, whoa yeah. So, we start out by asking, in [a] positive [way], about the baby, the pregnancy, the relationship with the spouse, and we kind of ease into the other things. And then this stuff always comes out in those conversations, sometimes it doesn't. The whole point of our assessment is just to kind of get a starting point of what home visitors are going to be getting into and what they have to work with as far as their [program recipients'] knowledge of milestones and development, and as far as their past. Some of the home visitors don't like the parent survey, and they don't like to read it because they just don't, they want to just try to be positive and not think about those things. (Anne, HFA supervisor)

In the study, participants talked about difficulties they had getting accurate responses from HFA program recipients due to fear of retaliation from abusive partners, shame, and mistrust of the home visitor. Therefore, just like during Therapeutic Alliance Building, home visitors had to work on their relationship skills and building trust to adequately help their program recipients. Natalie, a Dual Role Specialist, talked about a mom she had that “passed the RAT... and then afterwards she told me, you know, that she was being abused, like, months later and she said she just didn't want to put it out there.” For Susan, a Family Support Specialist, the difficulty with the RAT screening also included families’ responses based on the here and now, not the upcoming crisis.

[With] other families where we have done a big screen and it comes, like, the least amount of markage you can get, but, you know that does not represent this family accurately. Right? And so, you question mom like, hey, like, I know you guys are dealing with what you're dealing with how come this score it looks like this? Like, are you just good at answering questions so they don't represent your family? Like, for one month, for instance, she said that. We did a RAT and relationship assessment tool and it scored 10, which is the least amount, which would make me not need to, safety plan with you, just give you like a domestic violence numbers and resources. And I said, why do you think it scored this? And she said, well, because he's not here right now. They would say, like, oh, well, he's in jail right now, but then next week he's out and, you know, the score is, should be up. And it's just really about meeting families where they are and like what they're ready to deal with. (Susan, Family Support Specialist)

Susan goes on to talk about the frustrations she had in creating a safety plan with program recipients that indicated there was family violence in the home while maintaining her motto of meeting people where they are.

I mean, I've always felt comfortable addressing screens because I feel like it wasn't anything hidden, like, from the families. That I did know it wasn't a hidden factor of their relationship, like, it was a, a known thing. And I think the hardest part about it is they get this screen in and it's very high positive. And then you want to start safety planning and that's just not where that family is like, or that really that mother, that's not where she is for. And so, you kind of watch it play in that cycle of violence and I guess that kind of gets hard because it's like after your third time doing this you want a safety plan. And there's still no plan to leave, and there's still no plan for if you need to leave, and it's kind of like, you're just stuck in a gear type of deal..... Or that same mom, like she ended up getting her husband deported, you know, and that was from the violence. And I mean, that was her safety plan. Could she plan that with me? No, but I guess in her head, she was like, if it gets as far, this is what I'm going to do. (Susan, Family Support Specialist)

Safety planning, an intervention required by the HFA program based on program recipients' answers to the RAT, was discussed by participants as not only including tangible safety procedures written out, but also as a verbal exchange individualized to the unique needs of the family.

Normally, when they disclose the violence, it depends on the situation, 'cause if dad is in the home, most of the time I do not give like, that type of referral that

can be, like, paper or something that he can find. But we do have like this lipstick thing. And if you open it, I have like, the number to the domestic violence thing. And that's something that the partner wouldn't even think that would be a referral. So, I normally do something like that, or I'll just have a phone call and tell them over the phone a number they can call, something to kind of keep it, you know, to keep her safe. (Natalie, a Dual Role Specialist)

Another worker talked about how using a safety plan, the RAT, and other screenings led a father in her family to realize this was not an environment he wanted to raise a child.

We discussed a safety plan, and we have a card that has some safety information, but his case was a little, uh. I think through the screenings, eventually, he realized that it was not a situation he wanted to keep his child in, and he did end up, when they were in a relationship, he did end up gaining custody and I continued to see him because he had custody. So, I had done the visit with him when he was in the mother/father unit and then continued when he was the primary guardian. So, we just basically discussed it, discussed, you know, his feelings, the same way we would for a mother just addressed it from, you know, let's, let's figure this out, let's figure out next steps. I, you know, of course, I said this is concerning, I'm concerned, and this is why, [because] you said this, and that's not, let's talk about that more, you know. (Margot, Dual Role Specialist)

Ruth, a Program Manager, talked about how administering the RAT can vary due to program recipient answers. In her program, administering the RAT more than annually only occurred if it was part of the safety plan created by the home visitor. As Ruth states,

“It's [RAT] going to be administered more when they [home visitor] figure out that plan because it's a plan they have to do if they find somebody that, you know, is experiencing it they work on it that plan for them.”

Interview participants were asked about whether they had conversations with their families about pregnancy intention for the current target child, especially considering that how a parent feels about the pregnancy is a standard question asked on the parent survey. Participants stated that having conversations early on about the pregnancy were normal, but they did not always ask about whether the pregnancy was intended or wanted. One reason workers did talk about pregnancy intentions with their program recipients was because the pregnant woman or new mom brought up the topic as demonstrated in the below quote.

So, before we go out are we have an assessment worker that goes to each of the families and does an assessment to see if they qualify for Families [HFA] right? And so, in that, she does ask, like, was this a planned pregnancy um, and sometimes she does get more facts of, like say mom was thinking about an abortion or foster care, not foster care, adoption, or something like that. So, we do get that before we go in with our, that would be the TC [target child], so with our baby. And then, as you get to know mom and build this, like, wow, are you excited for [your] baby or whatever, like building that rapport. She, she tends to tell you how she feels, depending on each family. But she tends to tell you how she feels about the pregnancy. I've had moms who said they just weren't excited. And then, like, family members convince them to have the baby, or like, they weren't excited and then they found out that they're having the gender that they

wanted. So now they're excited, so. And it comes out in conversation, I guess you can't really miss it because the way people act towards their pregnancy and then you, kind of, you know, not poke, but you're asking questions and so it's going to come. (Susan, Family Support Specialist)

Another reason participants might talk with a pregnant woman or new mom about the intentionality of the pregnancy was because the worker had a dual role and was the one administering the parent survey as shown in this quote by Lucia, a Dual Role Specialist. Lucia said that in her Parent Survey Assessment, where the screening questions were conversational in nature, she asked about how the family felt when they found out they were pregnant. For Lucia this conversation then led to a conversation about IPV. Lucia said she starts her conversation/screening by asking general pregnancy questions.

Pretty, you know, easy questions about their pregnancy, you know when did you start your prenatal vitamins like how are you feeling, can you feel the baby moving stuff like that. And then from there, I kind of go into how did you react when you found out you're pregnant? How did dad react? Is dad involved to talk with? Then it kind of goes from there. And then that's when I can kind of talk a little bit about well you know, do you, do you guys fight at all like, how do you guys manage that? And then she might say a little bit more than that might lead into you know, domestic violence. (Lucia, Dual Role Specialist)

Natalie, another home visitor with a dual role, found that lots of her female program participants talked about wanting abortions with one mom talking about keeping the baby because it was her partner's first child.

I've had it in the, um, FRS [Family Resource Specialist] part. Um, I hear a lot of them that say that they wanted to have an abortion...but then once they have the child, they said that they're glad they didn't have the abortion. But I also had one case where she wanted to have the abortion, but she [was] like 6 months and she couldn't have it because she was so far along. Then another parent kept the baby because this was his first child. Then they ended up breaking up then she ended up resenting that she didn't get the abortion, so. (Natalie, Dual Role Specialist)

Megan, a Family Support Worker, offered another viewpoint about expectant parents who initially did not plan the pregnancy but were later excited.

If you read a lot of the surveys [parent survey], there's a lot of them that were we weren't planning a pregnancy, it just happened. Sometimes they feel that this will bring them back together, mom and dad better together, um. Some would say, oh, we weren't happy at first, but now we are, had to sink in kind of thing. So, yeah, I've, I've had surveys like that um. By the time I get to them after the parent survey, they're already gung-ho and out at Target buying everything underneath the sun for the baby. I think what it comes down to is at first, everybody's scared when they find out they're pregnant. How am I going to pay for diapers? How am I going to, you know, just the cost of living with children, you know, how am I going to do this? Um. I think that's a lot of it. Is, if you're not in a secure relationship, that's another one, you know, like is he going to stick around? Um, am I going to be doing this on my own? And I think what, once that all hits in, and they do some critical thinking. I think that's when it's like, oh, okay, I'm

pregnant. I'm having a baby. I'm gonna be a mom. And it's okay, I can handle this.
(Megan, Family Support Worker)

Home Visiting in the Time of a Health Pandemic

Going into the current research project, the role of the COVID-19 pandemic was not a general consideration because when the university IRB application was submitted, the widespread virus had not yet been deemed a pandemic concern. However, very shortly after the IRB approval there was a university wide decision to discontinue in person interviews and other in person research efforts. Therefore, the interviews and focus group for this project became virtual. The researcher also quickly learned, after the first interview, that the impact of the pandemic on HFA and home visiting in general was at the forefront of many staff members' minds.

Participants shared a variety of statements about the programmatic changes they were having to go through to safely respond to the COVID-19 pandemic. Many of these statements discussed frustrations with the inability to see families in person but acknowledged the need for distance. For Bernadette, a Family Support Specialist who was interviewed for the study at the end of 2020, outside visits had been a possibility until recently, so she was still adjusting to an all-virtual format.

Yeah, it's totally different now because we're only doing mostly like, except for, like, trouble clients or like extreme circumstances, we're only doing like virtuals, which is like, Google, Duo, Face Time, stuff like that.... Yeah, that's been difficult. Usually I mean, before now, before the governor, like, completely put a stop to it, usually I, we were allowed to like go and do like, visits outside as long as they had, like, an outdoor porch area, and it was like, spaced out enough.

Usually, I like to do that in the beginning because I think like, face-to-face, kind of builds that rapport in the very beginning. It's so hard to, like, try to cultivate that relationship over the phone or Face Time, especially if they don't have like Wi-Fi or the ability to do video, it's, it's really difficult. So, I think, I've been finding that pretty difficult. But for the people who I have been able to see in person, at least once, I think it's been going pretty well. But engagement has definitely been a thing. (Bernadette, Family Support Specialist)

Other participants echoed Bernadette's statements about the frustrations and difficulties with the all-virtual format. Kellie, a Dual Role Specialist, talked about problems she ran across with one family when she switched from in-person visits to telephone calls but attempted to keep the same time slot.

Like, I have a family that I used to go, like, at 3:30pm to 4:30pm, um. She would pick up the child at 3 o'clock at HeadStart and then I'd be sitting in the street waiting for her, like, at 3:15pm and she'd pull in and we'd start. Um, we can't do that now because it's too hectic for her to be on the phone cause it's a phone call at that time. Because when I was in the home, the kids would just come off the school bus and come through the house and she'd say, go get a drink or put you backpack away, whatever. Um, now it's more hands on from mom, and she can't be on the phone while she's doing that. (Kellie, Dual Role Specialist)

Frustrations for Lucia, a Dual Role Specialist, were not always with program changes involving family interactions. As a health department employee, Lucia, along with several other participants in the study, was asked to perform pandemic related duties on top of her current HFA tasks and caseloads. Being asked to add duties onto her

existing full time HFA job, to her, meant that her work as a home visitor was being belittled: “Well they feel like, the health department, feels like our program doesn't do much. So, everybody's in the program being pulled to either contract, contact tracing, in doing the vaccines, or either doing the COVID testing.”

Despite most participants talking about the negative aspects of the pandemic, there were some comments that reflected positive changes and opportunities for the HFA program and home visiting. Shawna, a Family Support Specialist, talked about how new families she met during quarantine did not know anything different than virtual home visits.

Actually, with new families it's pretty easy because they don't know the old way. They don't know me coming into their home. They just know that there's a camera, and screen sharing, and YouTube, and things like that. That is very easy. My older families who [have] had me in their home they miss the visitor to come in the home and show them more one-on-one compared [to] on the computer.
(Shawna, Family Support Specialist)

During the focus group, one supervisor talked about the flexibility virtual visits have provided for not only program families but home visitors as well. Felicity, Clinical Supervisor at a local health department, shared how her program now has evening and weekend virtual home visits which better meet the needs of some families.

I can see that, um, a challenge, it's also been a blessing because now, if somebody needs an evening or weekend visit, they've been able to do that. It's much more convenient and they've [home visitors] been willing to [do] that without anyone

ever even saying you have to do that. They've just done that, um, because they feel like well, I'm home I don't have to go anywhere so I'm not out driving around at night by myself or having to come to town on a Saturday. But if I'm home, we can go ahead and we can do a visit. So, we are seeing, which is great for parents who work, or the kids are going to HeadStart now and they're gone all day. So, I think we're seeing more families now that need a later visit or maybe even on the weekend, if that's what the worker and the family agrees to. (Felicity, Clinical Supervisor)

In response to the statement shared by Felicity during the focus group, Kathryn, a Program Manager, responded with her insights as a manager running an HFA program out of a non-health department setting. For Kathryn, her program never did work from home, so they have tried to maintain regular office hours throughout the pandemic.

We have been in the office through the whole thing. So, virtual visits were happening here from the office space. We work under a mental health clinic instead of a health department or anything like that. So, our guidance has been a little less clear on what we should be doing. And so, when our whole clinic, you know, all their programs return to face-to-face interactions, we were also expected to return the face-to-face interactions. And I know the health departments and things like that tend to be a lot more conservative in how they've approached that. The, the boundaries thing is definitely something that we have sort of stressed from the beginning, um, at least since I took over the role. Because I want our home visitors to have some, some walls around it and also to, um to make sure

that when we were going back to face-to-face, families, weren't expecting that kind of infinite flexibility. (Kathryn, Program Manager)

Data collection for the current research project spanned a 10-month time frame from the end of 2020 to the last quarter of 2021. Therefore, the researcher was able to capture thoughts from participants during different phases of the pandemic. In the following quote by Tamara, a Family Support Specialist, she talked about how she and her co-workers were starting to go back into the office after working from home due to more people getting vaccinated. She also shared how she structured her virtual visits with families who were still being quarantined.

Then we were told that, you know, we can't, that they only want it, like one person in the office. Now since a lot of people are getting vaccinated, I'm going in once a month. And I'll run things out to families if they need them like diapers, wipes, or necessities. But I do a lot on email because then I send the handouts through GGK [Growing Great Kids]. And then I'll get on the web, um. I have a mom that likes Peppa Pig. And I showed her how YouTube you, you could sit down, since the kids like tablets, you can actually listen to someone narrate the books. And that's still getting reading to your child. Sing alongs, puppets, things like that is what I, I mean you're stuck in the house, so you've got to do something. (Tamara, Family Support Specialist)

As vaccines became more available to the public, home visitors started having more opportunities to visit face-to-face again with families, though with precautions in place. Kathryn, a Program Manager, shared a little about these transitions.

We started transitioning back into, um, face-to-face visits in I think about June as well. My whole staff is vaccinated, which has made things easier in that regard. We started out with just outdoor visits, in when the weather was still pleasant. As the weather got hotter, and families started to feel more comfortable with their home visitors, being out there, we started giving the home visitor the option to offer in the home visits with everybody over the age of two masked, and we provide masks for children and for adults. And now we are up to, we do all of our visits either, we do them face-to-face outdoors when possible, indoors when not possible. Everybody is supposed to be masking. And we have, we're following the HFA guidelines and the 8th edition best practice standards of really prioritizing those virtual visits for when we can't provide services any other way. (Kathryn, Program Manager)

When asked for clarification on how virtual visits are prioritized for families who cannot receive services any other way, focus group members mentioned program recipients with health vulnerabilities like prematurely born children, immune compromised members in the home, etc. Linda, a Clinical Supervisor, went on further to talk about vaccination rates, high risk transmission areas, parents' abilities to interact virtually, and workers' willingness to do face-to-face visits during a pandemic as factors in the transition back to all in-home visits.

But you take into account the parent and their ability to actually engage with the worker virtually cause some, most people can do that, depending on the parents' cognitive limitations, whether they've been vaccinated or not. All of that plays into it. And what is actually going on with that family, if the worker is

vaccinated... One of the things that I think that we should remember is that depending on where you are, um, the concern and the risk can differ, you know, pretty, you know, a great deal. But, if you're, we were in, we are in a high-risk area of transmission. So, we considered all things before we said, you know, uh, let's pull back from this or not. So, we had to consider what was actually happening in our area. And one of the things that we've done is, you know, we just monitor it. And because the last thing we want to do is, or any staff, to go into a place that's not safe, where they could actually contract COVID themselves, or even though, even if they're vaccinated, we just, there's some risks that's just not worth taking. (Linda, Clinical Supervisor)

Chapter 6: Discussion

Overview

The current study sought to answer the following research question: to what degree do home visiting staff members' personal and professional identities impact their ability to effectively screen and support pregnant women and new mothers around the topic of unintended pregnancy and IPV including RC? Research participants shared that their personal and professional identities, which are often interwoven, do indeed greatly impact their work with pregnant women and new mothers. To discuss sensitive topics like unintended pregnancy, IPV, and RC, the home visitors often relied on engagement techniques first developed in their personal identities and further honed with their professional identities as home visitors. The home visitors would then rely on their extensive professional training to initiate screenings around sensitive topics with pregnant women and new mothers while continuing to pull from basic clinical skills to offer emotional support. The blending of personal and professional identities to use these clinical skills were often seamless with the home visitor oftentimes not even able to pinpoint the usage of skills and techniques. The study found that the more a home visitor used their multiple identities to interact with clientele, the better the ability to effectively screen and support that clientele around sensitive topics.

To explore the study research question, home visitors were asked about their personal and professional understanding of the research topics. These research topics included pregnancy intention in the high risk populations they serve, their perceived comfort level and ability to ask sensitive questions like experiences of intimate partner violence and reproductive coercion, their opinion of availability and quality of training

designed to address sensitive questions, and the support they received from supervisors and co-workers around screening for and providing resources around sensitive topic areas like intimate partner violence. Research participants demonstrated a level of familiarity with IPV including a level of comfort in screening as the RAT, an IPV screener, is a standard screening tool used in HFA. However, participants showed little to no awareness of the term reproductive coercion nor were they regularly talking with HFA program recipients about reproduction. During the first few interviews, the term unintended pregnancy was used by the interviewer, but participants talked about whether a pregnancy was wanted nor not. The interviewer then changed her language about the phenomenon to pregnancy intention to better match how her participants thought of the issue. Due to the current healthcare crisis with COVID-19, which was first and foremost in participants' minds, the study also ended up focusing on how home visitors and the HFA program in general were able to continue to provide support and services in a time of social isolation, quarantine, and virtual visitation.

Unfortunately, the issues of intersectionality, overlapping oppressions and systemic racism, were not addressed within the study. Intersectionality, as discussed in the previous chapter on theory, did inform the purpose and focus of the study. However, the researcher did not directly address intersectionality in the interview guide or focus group questions nor did intersectionality come up as a theme within the data.

Factors Associated with Home Visiting Service Delivery

Six themes emerged from interviews and the deliberative discussion focus group. Study participants' statements echoed the MIECHV goals for home visiting which include preventing child maltreatment while improving maternal and child health,

utilizing positive parenting approaches, and having a focus on school readiness and child development (HRSA, 2021c). Additionally, study participants shared how their personal and professional identities helped shape their perceptions of their roles within the home visiting field including in terms of that role, its meaning, and the expectations associated with that role. The perception of their roles in turn informed their subsequent behavior, reflecting the tenets in Identity Theory (Burke, 1991; Burke & Tully, 1977). Additionally, study participants discussed how they use this perception of their roles to assist in creating a therapeutic alliance with program recipients and creating supportive relationships with fellow co-workers. Essentially home visiting staff's use of self, which is formed as a social construct (Identity Theory), served to turn participants into social change agents wherein program recipients became persons wanting to change. This process reflects the core foundation of Bordin's Theory of Therapeutic Alliance (1979). Role perception and relationship building were key study themes of Personal versus Professional Experience, Therapeutic Alliance Building, and Home Visiting in the Time of a Health Pandemic that emerged from the study.

Reproductive Health including Reproductive Coercion. Participants were also asked to talk about their process for sensitive topic screening and providing support to mothers and family members who screened positive for those sensitive issues. During the study, the researcher discovered that the actual term of reproductive coercion (RC) was unfamiliar to participants. This was not surprising to the researcher as this is a relatively new concept and is not something that is included in the HFA curricula. Instead, the researcher initially used the term pregnancy intention to begin talking about the core ideas of RC as pregnancy coercion (i.e., being pressured or threatened by a partner to

promote pregnancy), birth control sabotage (i.e., interfering with birth control used by a partner), and abortion coercion (i.e., being pressured or threatened by a partner to have or not have an abortion) are all subdomains of RC (Grace & Anderson, 2018; Miller et al., 2014). Pregnancy intention and RC are related in that identifying if a pregnancy was not desired by either partner can lead into follow up questions about the previously mentioned RC subdomains. Pregnancy intention was used by the researcher to start a conversation with the home visiting staff about reproduction with the goal of learning more about RC screening in HFA programs. However, it is important to note that pregnancy intention and RC are not synonymous constructs.

Even using the term pregnancy intention to begin a conversation about reproduction was fraught with difficulties. Participants stated that each program family is screened for whether the pregnancy was wanted during the Parent Survey Assessment, but home visitors did not seem familiar with the term pregnancy intention, just the terminology of wanted versus unwanted pregnancy. However, only participants who were Dual Role Specialists administered the parent survey during their duties as a Family Resource Specialists. Therefore, only Dual Role Specialists asked about whether pregnancies were wanted or not. Participants who only identified as Family Support Specialists/Workers were able to view the answers on the parent survey, but they did not typically follow up on the program recipient's responses. Even when specifically asked by the researcher if interview participants talked with parents about pregnancy intention, most participants said they did not and that by the time they started working with a family for routine home visits, the parents were excited about the pregnancy. However, there were some exceptions (e.g., when workers talked about pregnancy intention) provided by

the participants under the theme of Addressing Intimate Partner Violence/Reproductive Coercion in Families. Therefore, whether the pregnancy was planned or not, or wanted or not, was not something typically covered by workers.

Due to the lack of consistent discussion of unintended pregnancy and reproduction in general among home visitors, more in depth training opportunities and interventions should be made available to them. Alio (2017) recommends that home visitors should take a more active role in reproductive planning as they have more time to discuss reproductive planning and concerns with women and their partners than physicians or other traditional health workers. The specific intervention Alio (2017) discusses is the Reproductive Life Plan (Handler et al., 2013), which has workers create personalized goals with clients about their decisions around having children including the number of children and timing of pregnancies. Another training opportunity using an intervention related to reproduction is offered by Futures Without Violence (2021). This program, called Reproductive Coercion: Interference with Contraception and Pregnancy Planning, includes an e-learning module designed for human service providers of all skill levels along with a pamphlet-based intervention asking key questions to program recipients about reproductive coercion (Futures Without Violence, 2021). Based on the current study's results, additional training and discussions around reproductive health are needed for home visitors as they routinely interact with pregnant women and new mothers who are at-risk for poor pregnancy related health outcomes in part due to lack of control or intention related to reproduction.

Intimate Partner Violence Screening. Using the RAT to screen for IPV was a standard practice for all participants. Participants noted that they received extensive and

rigorous training on using all screening tools and curricula in the program during the onboarding process of becoming an HFA staff member. Thus, all participants reported feeling some level of comfort screening for IPV and depression, since as HFA home visitors, they administered these screening tools on a regular basis. The level of preparedness workers felt about IPV was clearly vastly different from the comfort level and training related to reproductive health. When discussing participants' training regarding other sensitive areas like mental health concerns not related to depression, most interview participants said this was lacking. Two participants from the interviews noted that they had been to a mental health crisis training but still felt there was more to learn about working long-term with individuals living with mental health issues. Participants from both the interviews and the focus group also talked about how the HFA protocols require ongoing annual trainings related to programmatic target topics. Additionally, some HFA programs also encouraged home visitors to seek additional trainings of their own interests beyond those that HFA required. According to the focus group participants, each program manager at each individual HFA program also has the ability to assign training hours beyond what the national HFA standards recommend. Therefore, advanced level trainings around IPV may be something that could interest home visitors in the future as they meet their training requirements.

Home Visiting's Response to the Pandemic. Changes in how home visitors do their jobs due to the COVID-19 pandemic was in the forefront of the participants' minds. Management in HFA programs had to continually adjust visit structure to keep both workers and program recipient families safe. This meant continual monitoring of transmission rates per locality, vaccination rates, HFA guidelines, and state and county

ordinances. New national HFA guidelines were produced during the pandemic which allowed home visitors to continue visiting with families either via video or phone calls and visitors were encouraged to ask open-ended questions to parents to gauge interactions with children (HFA, 2020). The HFA program staff were already well versed in providing support to families around basic needs like food, baby needs like diapers and formula, transportation, and stable housing. However, once quarantine and social isolation became standard, these basic supplies and resources were scarce and at times hard to access. This led to home visitors becoming the central hubs for information and resources because of their community connections to these resources (Williams et al., 2021). The pandemic has allowed home visitors to shine by meeting their families' needs with creativity, flexibility, and compassion. The current health crisis has allowed some HFA programs and workers to make changes that may last beyond the pandemic such as changing their availability to include after-hours and weekend access to better meet the needs of working parents, making virtual meetings a standard alternative instead of missing visits when parents cannot meet face-to-face, and incorporating emotional check-in times with families beyond what the curricula requires. These changes reflect an acknowledgement that it is difficult out there for all of us. Simply put, home visitors, like many other service providers, realize that the restrictions and changes introduced by COVID-19 are the new norm (Williams et al., 2021).

Strengths and Limitations

Study methodology, including research design and utilizing a virtual format, provided both strengths and limitations to the overall study. The current study utilized two methods, interviews and a deliberative discussion focus group, which meant a

stronger overall study than interviews alone as the deliberative discussion focus group served as a means of member checking the interview data, as well as providing new data. However, there were only four participants in the focus group, while a fifth member who was unable to attend the scheduled focus group time, was provided the draft interview results and asked the focus group questions in an individual interview. The study would have been strengthened by having all the home visitor managers participate in same focus group because the power of focus groups comes from conversations within a group setting. The study also only captured the voices of front-line workers and managers. The study did not interview home visiting clients, so the findings do not represent all levels of individuals involved in home visiting programs.

Additionally, the researcher was unable to conduct focus groups or interviews in more urban areas in Maryland due to lack of response from eligible programs. HFA Program managers in urban areas of the state were approached regarding interest in the research topic, but either the program managers did not respond to the inquires or were otherwise committed to other research projects and did not wish to overburden their workers. Even though lack of representation from urban areas was not ideal, the research data received did represent generally under-researched areas of the state.

The use of a qualitative research design for this study brought its own unique blend of strengths and weaknesses as well. As the sole collector, analyzer, and interpreter of the data there is a risk of bias from the researcher. To minimize and explain this risk, the researcher used several methods to ensure trustworthiness of the data as is recommended in qualitative research (Carlson, 2010; Maxwell, 2012). Any research, quantitative or qualitative, is subject to researcher bias with qualitative study seeing

acknowledged and discussed bias, or reflexivity, as a means of bringing in data trustworthiness (Creswell & Miller, 2000). For the current study, the researcher used reflexivity to acknowledge this bias by discussing her background, role as a researcher, and assumptions on paper in the current document and in person/virtually with her committee or peer debriefer throughout the proposal, data collection, and interpretation phases. The role of the peer debriefer was discussed in detail in the Methods section under the sub-section Researcher Role. A deliberative discussion group was also conducted with the intention of presenting themes from the home visitors' interviews to the group beforehand and then asking the group if those themes and a sample of matching quotes were interpreted by the researcher correctly. Utilizing the focus group for member checking allowed the researcher to ask whether the results were consistent with the focus group members' experiences, thus providing a way to bolster the trustworthiness of the data (Creswell & Miller, 2000).

Using a virtual platform, as a requirement for conducting research during COVID social distancing restrictions, to interact with participants also came with its own strengths and limitations. By having a virtual platform, the researcher and participant were able to safely interact even during times of social distancing restrictions which was a major strength. Meeting virtually via video conferencing was familiar to all the participants and something most of them were using daily for work. Due to this familiarity with virtual meeting, many participants opened up quickly about their experiences and really seemed to enjoy being in the study. For those few interviews where participants seemed hesitant to open up about personal reflections, technology

issues seemed to account for the majority of the hesitancy as the researcher and participant could not get into a consistent conversational flow due to these glitches.

Just as home visitors described with their program recipients, technological issues plagued some of the interviews and during the focus group. The researcher, and sometimes the participant, had to turn off video to conserve bandwidth to stop glitches and freezes. During two interviews the lag times were so bad that the researcher had to dial in via telephone instead of using the video function. The interviews were able to continue but some of the portions of the conversation were not captured in the meeting transcript during these glitches. The same issue with lag time arose in the focus group resulting in all participants turning off their cameras. Unfortunately, not all study participants were able to use a hard-wired connection to the internet as the only internet option in their homes was a mobile hotspot. Ideally, future research using virtual meeting technology will be done with users having hard wire connections to reduce the risk of low bandwidth from wireless connections.

As previously mentioned at the start of the chapter, the issue of intersectionality was not directly brought up with participants during data collection, nor did the issue arise from the data even though intersectionality did inform the purpose and focus of the study. The lack of purposeful inclusion of intersectionality into the data collection via participant questions from the interview guide and focus group guide was a limitation of this study. Research has shown that evidence-based home visiting programs, like Healthy Families America, can be used to reduce racial and ethnic disparities in maternal and child health (Lewy, 2021). Thus, discussing these disparities and how home visitors can impact change needs to be addressed in future research.

Implications

By understanding managers’/supervisors’ and front-line staff members’ screening procedures and service delivery approaches around sensitive topics, the current study sheds light on potential emerging best practices for screening implementation. By highlighting these best practices as well as program deficits, the current study can inform future research studies and home visiting program developers. Below is a discussion of implications related to policy, practice, and future research for the field of social work and home visiting.

Implications for Policy. The findings from the current study revealed a number for policy implications specific to changes in home visiting programs, but social worker programs in general may also benefit from these suggestions. Home visitors using the HFA curricula discussed how they felt well prepared to address IPV with their program recipients, but they did not feel as comfortable addressing reproductive or mental health issues. HFA, as well as other social service-related programming, should consider adding required reproductive health screenings along with training related to how to talk about these topics, how to administer the screening effectively, and how to respond to positive screens requiring an intervention. Few reproductive coercion screenings have been created with detailed psychometric analysis testing for validity (Grace & Anderson, 2018). However, recent studies have demonstrated that using the Reproductive Autonomy Scale (Upadhyay et al., 2014) or the 10 questions developed by Miller et al. (Miller, Decker, et al., 2010) to measure reproductive coercion can result in moderate internal reliability (Grace & Anderson, 2018). HFA and social service-related programs should consider using those screening questions as part of their routine assessments. The

same consideration for programmatic change should also occur around an expanded view of mental health. Research participants discussed how the current curricula prepare them to talk about depression but not any other mental health conditions, or even what to do during a mental health crisis with home visiting program recipients. More training on mental health crisis response should be mandated for home visitors and social workers with at least annual refreshers.

Another policy implication resulted from the current study is related to workforce development for home visitors within the HFA program. As mentioned above, HFA home visitors need to implement more conversation and planning around reproduction with home visiting program recipients. HFA may want to look to the Nurse-Family Partnership (NFP) model which has demonstrated fewer closely spaced pregnancies for their program recipients (Nurse-Family Partnership, n.d.). By working with program recipients to establish goals with the intention of economic self-sufficiency, a core program goal for NFP, home visiting nurses have continual conversations with program recipients about better pregnancy planning. Pregnancy planning would including timing, life goals like completing education and career advancements which could be impacted with close intervals between pregnancies, and the economic impact of having closely timed pregnancies on the women (NFP, n.d.). By viewing reproductive planning through the lens of economic development, HFA may be able to achieve better maternal and child health outcomes. Making personal economic development a priority for both staff and program recipients of HFA may also allow home visitors the opportunity to discuss their own issues related to low pay and stagnant job/education opportunities with supervisors, an issue brought up in the study. Thus, home visitors may be able to exhibit modeling

behavior to their program recipient families as the home visitors establish their own life goals with their supervisors. However, home visiting supervisors will also require additional training and guidelines from HFA on how to support these economic development and life goal conversations with their supervisees as home visitors in turn have conversations with program recipients.

A final policy implication gleaned from the study findings is related to the format of service delivery. During the study, the researcher talked with home visiting staff in various stages of social distancing due to the COVID-19 pandemic. Participants talked about utilizing more virtual formats with the home visiting program recipients as they were either not allowed to meet in person or they had to maintain adequate distancing (i.e., at least six feet apart with appropriate facial coverings). Participants also talked about lessons learned from the virtual formats, and the pandemic in general, including offering more flexible times and dates to meet with families to accommodate working schedules for participant families. The increased flexibility included virtual visits offered evenings and weekends, which some families responded well to as noted in the deliberative discussion focus group. Future policies for home visiting programs and other social service organizations should look at offering services outside of traditional business hours to accommodate working families who still want or need services but cannot meet during daytime hours.

Implications for Practice. Even though the current research was not held with social worker practitioners, the findings from this work can inform future social work practices. Study participants, under the themes of Therapeutic Alliance Building and Keeping Families Engaged, talked about the importance of flexibility, individualized

treatment, compassion, appreciation, and ingenuity as key factors in successful interactions with program recipients. Research participants had to utilize those skills to keep their families interested and involved in the HFA program during massive changes in both service delivery and program procedures due to COVID-19.

Research has consistently shown that the therapist effect (i.e., variability of characteristics within therapists themselves) accounts for some of the unexplained changes in patient outcomes, while those having a robust therapeutic alliance has been shown to be a strong predictor of these positive patient outcomes (Arnow et al., 2013; Saxon et al., 2017). Even if a clinical intervention is performed consistently and correctly across multiple therapists, there is an effect from the individual therapist and how they engage and interact with a patient that influences patient outcomes. Thus practitioners, social workers and home visitors can use their personal experience and attributes (use of self), as well as professional trainings and knowledge to successfully work with clients, patients, consumers, and program recipients. The current study showed how an individual worker can be the linchpin in keeping a family consistently engaged, in a service delivery program through both good and difficult times, like a national pandemic; this is a lesson any social worker can appreciate.

Based on the results of the current study, there clearly needs to be more focus on the program recipient's reproductive health within home visiting programs. It is important for home visiting programs to include discussions of reproductive health as part of the services offered as these programs are designed to work with individuals and families who are at-risk for poor pregnancy related health outcomes. As discussed earlier, poor pregnancy related health outcomes can result from the individual's lack of

reproductive control or intention (Alio, 2017). With home visitors having the built-in time over weeks and months, they would be able to provide future reproductive planning conversations and assist with access to current and future health care needs with at-risk individuals and families.

Great strides have been achieved in Maryland regarding training opportunities for home visitors around many of the social issues (e.g., IPV, depression, etc.) experienced by program recipients. Home visitors receive site specific trainings on program and curricula, as well as having the opportunity to participate in the Training Certificate Program offered by the University of Maryland, Baltimore County (Maryland Governor's Office for Children, 2019). However, for the HFA program, the training opportunities are just a reflection of what is covered in the program's screeners. As there is very little formal structured conversation about pregnancy intention, reproductive planning, and reproductive choice in the HFA screeners, the topic of reproductive health and decision-making is typically overlooked in these programs. By not discussing reproduction in a universal screening process, the HFA program is missing a key opportunity to empower its program recipients to make informed and healthy family decisions in the future. The findings from this study can be used as a starting point for the HFA, and other home visiting programs, to think about how best to use reproductive health and decision-making information as a standard portion of the program.

Implications for Future Research. This study, along with others, have shown that home visitors are able to effectively engage program recipients (Gill et al., 2007). The current study has demonstrated how resourceful, and stressed, home visitors can be when their program and community change suddenly. However, even without a pandemic,

home visiting with high-risk families with limited resources is stressful and can lead to burnout, low job satisfaction, and high turnover, especially during reorganization periods for programs (Gill et al., 2007). Therefore, future research should examine the factors that can improve job satisfaction, and reduce worker stress, burnout, and physical and mental health of home visitors and their supervisors.

Home visiting programs also implemented virtual visiting as a standard part of services during the pandemic with a period of time where virtual visiting was the only visiting offered. The virtual visiting oftentimes did not allow home visitors to visually witness whether parent-child modeling behaviors were implemented. Therefore, future research should explore to what degree home visiting programmatic outcomes change because of using virtual visiting. Home visitors also changed up how and when they provided materials to families including dropping off packages to front doors, creating activities to promote engagement, sending materials virtually via email, expanding visits hours to include evenings and weekends, and more check ins with families about emotional well-being related to stress from the pandemic. Future research should explore whether these additions to services persist even once a new normal is established as a country we moved from pandemic to endemic status.

The current study also demonstrated that home visitors felt that they had an extensive amount of training to screen for IPV, do safety planning, and offer community resources related to family needs around IPV. However, according to the Maryland Governor's Office for Children, only 7% of women screened in these programs indicated that they were experiencing IPV (2019), which is dramatically different than the 25% that the CDC has reported (CDC, 2021b). Considering the target population for home visiting

programs are families at risk for poor maternal and child health outcomes, this very low positive IPV screening rate is troubling. Future research should examine the factors related to this low screening rate. The research should include exploring how screening tools can be improved in the detection of IPV, examine how home visitors are asking these sensitive screening questions and whether it influences IPV detection, whether these workers feel they just acquired sufficient knowledge and skills to be proficient at detecting and addressing IPV (Tandon et al., 2008), and exploring if the timing of screenings influences detection of IPV. In addition to the focus on IPV screening, it is critical that all home visiting programs emphasize the importance of discussing the impact of violence on women as well as its influence on the physical and mental health of the mothers and children within these high-risk families. Future research should also focus on more urban areas as well as the voices of HFA program recipients as the current study consisted of rural and suburban HFA service providers.

Future research should also look at the role home visitors can play in reducing racial and ethnic disparities within the field of maternal and child health. Home visitors can identify some of these needs through their regular screenings (e.g., reduced access to health care services or lack of consistent routine healthcare for pregnant women, new moms, babies, young children, and other family members). Addressing the health disparities are also commonplace in the work done by home visitors through coordinating care and referrals to various community services such as early childhood education and health care (Duffee et al., 2017), though home visitors may not be aware of the impact of their work. Thus, future research needs to ask home visitors more specifically about their role in reducing these health disparities.

Conclusion

Home visitors were asked about their personal and professional understanding of pregnancy intention in the high-risk populations they serve, their perceived comfort level and ability to ask sensitive questions like experiences of IPV and reproductive coercion, their opinion of availability and quality of training designed to address sensitive questions, and the support received from supervisors around screening for and providing resources around sensitive topic areas like IPV. The topics of unintended pregnancy/pregnancy intention, IPV, RC, and home visiting in general from the staff perspective were explored with research participants through the lens of personal versus professional identities and therapeutic alliance building. However, unintended pregnancy/pregnancy intention and RC were not consistently discussed in participant responses. The research study also discovered several factors that impact home visitors' ability to effectively screen and support pregnant women and new mothers around those topics including engagement, use of supervision, and new programs procedures (i.e., virtual visits). Overall, participants demonstrated flexibility, ingenuity, patience, and passion for their work as home visitors during a health care crisis the likes of which had not been seen for several generations. In general, home visitors indicated that they were well prepared to screen and support women experiencing IPV, but low positive screening rates seems to contradict those statements. Additionally, home visitors in the HFA program need more training and community resources around unintended pregnancy, general reproductive health, and reproductive coercion to better support families as reproduction issues also contribute to maternal and child health outcomes which are the core goals of HFA.

Appendix A

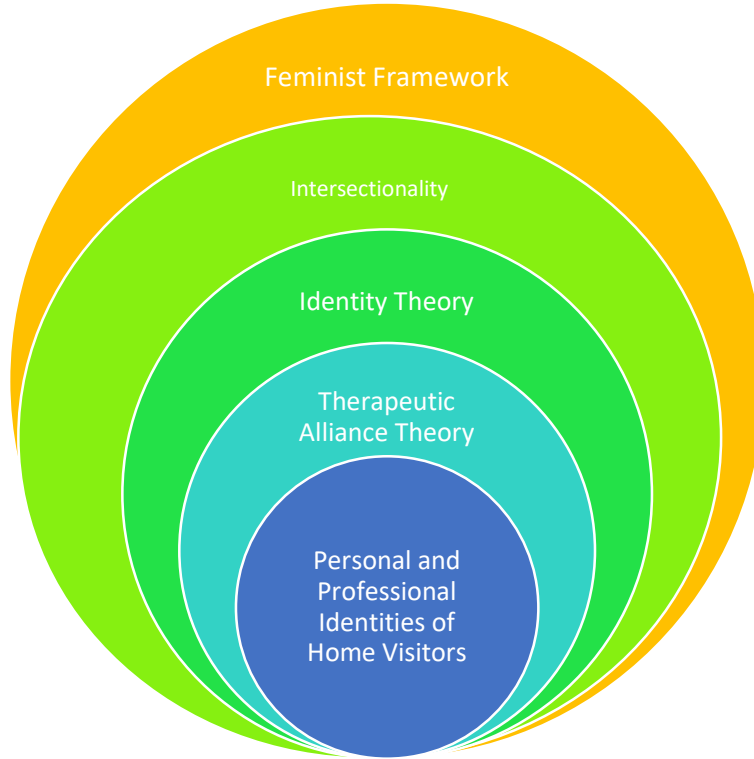
Breakdown of Target Populations and Outcomes Addressed by Evidence-Based Home Visiting Programs in Maryland

Program Name	Target Population	Outcome Domains Addressed by Program
Early Head Start-Home Visiting (EHS-HV)	Pregnant women, Birth-47 months	Maternal health, Child development and school readiness, Reductions in child maltreatment, Positive parenting practices, Family economic self-sufficiency, Linkages and referrals
Healthy Families American (HFA)	Pregnant women, Birth-48+ months	Maternal health, Child health, Child development and school readiness, Reductions in child maltreatment, Reductions in juvenile delinquency, family violence and crime, Positive parenting practices, Family economic self-sufficiency, Linkages and referrals
Home Instruction for Parents of Preschool Youngsters (HIPPY)	36-48+ months	Child development and school readiness, Positive parenting practices
Nurse Family Partnership (NFP)	Pregnant women, Birth-23 months	Maternal health, Child health, Child development and school readiness, Reductions in child maltreatment, Reductions in juvenile delinquency, family violence, and crime, Positive parenting practices, Family economic self-sufficiency
Parents as Teachers (PAT)	Pregnant women, Birth-48+ months	Child development and school readiness, Reductions in child maltreatment, Positive parenting practices, Family economic self-sufficiency

(DHHS, n.d.-a)

Appendix B

Theoretical Framework



Appendix C

Demographic Information about the Interview Participants

	N	Percent	Mean (<i>SD</i>)
Age	11		38.3 (<i>10.8</i>)
Gender			
Female	11	100.0	
Race/Ethnicity			
African American/Black	5	45.5	
Caucasian/White	5	45.5	
Caucasian/White/Hispanic	1	9.0	
Marital Status			
Married	3	27.0	
Divorced	1	9.0	
Single	6	55.0	
Separated	1	9.0	
Current Position			
Family Service (Support) Specialist	6	55.0	
Supervisor	1	9.0	
Dual Role Specialist (Both Family Resource and Support Specialist)	4	36.0	
Highest Level of Education			
Some College/Post High School Certificate	3	27.0	
Bachelor's	6	55.0	
Some Master's	1	9.0	
Completed Master's	1	9.0	
Length in Months of Employment			
In the Home Visiting Field			57.4 months (<i>40.5</i>)
In Your Current Position			40.8 months (<i>30.4</i>)
Have You Ever Been the Primary Caretaker for a Child			
Yes	6	55.0	
No	5	45.0	
Locality Participant Works in			
Dorchester	2	18.0	

Frederick	2	18.0
Mid-Shore	3	27.0
Washington	4	36.0
Has Participant Ever Lived in Work Locality		
Yes, currently	6	55.0
Yes, in the Past	3	27.0
No	2	18.0

Appendix D

Demographic Information about Deliberative Discussion Focus Group Participants

	N	Percent	Mean (SD)
Age	5	100.0	44.6 (8.8)
Gender			
Female	5	100.0	
Race/Ethnicity			
African American/Black	3	60.0	
Caucasian/White	2	40.0	
Marital Status			
Married	2	40.0	
Single	1	20.0	
Unknown	2	40.0	
Current Position			
Clinical/Program Supervisor	3	60.0	
Program Manager ¹	2	40.0	
Highest Level of Education			
Bachelor's	2	40.0	
Some/Completed Master's	3	60.0	
Length in Months of Employment			
In the Home Visiting Field			113.4 months (118.0)
In Your Current Position			50.6 months (51.6)
Have You Ever Been the Primary Caretaker for a Child			
Yes	5	100	
Locality Participant Works in			
Dorchester	2	40.0	
Mid-Shore	3	60.0	
Has Participant Ever Lived in Work Locality			
Yes	3	60.0	
Unknown	2	40.0	

¹One of the program managers had wanted to participate in the focus group but was unable to attend at the scheduled time. Therefore, the program manager met individually with researcher but was given the same information and script as the deliberative discussion focus group members.

Appendix E

Participant Pseudonym Assignment

Pseudonym	Program Role	Highest Level of Education (Major or Certificate)	Number of Months in Current Role	Interview (I) or Focus Group (F) Participant
Bernadette	Family Support Specialist	Bachelor of Science	15	I #1
Margot	Dual Role Specialist	Bachelor of Science (Psychology)	54	I #2
Natalie	Dual Role Specialist	Bachelor of Science (Human Services)	24	I #3
Kellie	Dual Role Specialist	Bachelor of Science (Human Services)	30	I #4
Megan	Family Support Worker	Some College (Phlebotomy)	96	I #5
Leslie	Family Support Worker	Some College (Early Education)	10	I #6
Shawna	Family Support Worker	Some College	96	I #7
Anne	Program Supervisor	Master's in Business Administration	36	I #8
Lucia	Dual Role Specialist	Bachelor of Science (Mass Communication, Publication Relationship, Spanish Literature)	16	I #9
Tamara	Family Support Specialist	Bachelor of Science (Child Development and Family Studies)	24	I #10
Susan	Family Support Specialist	Bachelor of Science (Child Psychology) and currently in Master's Program (Clinical Mental Health Counseling)	48	I #11
Kathryn	Program Manager	Master of Arts (Human Development)	15	F #1
Linda	Clinical Supervisor	Bachelor of Science and Currently in Master Program	60	F #2

Felicity	Clinical Supervisor	Bachelor of Science	132	F #3
Layla	Program Supervisor	Bachelor of Science	3	F #4
Ruth ¹	Program Manager	Master of Science (Human Services)	48	F #5

¹Ruth was the program manager who met individually with researcher but was given the same information and script as the deliberative discussion focus group members.

Appendix F

Interview Guide

Thank you so much for your participation in the interview today. As mentioned in the consent form, I am interested in learning more about how visitors approach asking difficult questions with their program participants. I want to hear in your own words the perspectives you have on screening pregnant women and new mothers. I anticipate that this interview will last about 60-90 minutes. During this interview I will be using voice recording equipment as shown here. I realize that you have already signed the written formal consent form, but I'd like to take this moment to ask if you have any other questions before we get started?

[Answer Questions]

I would also like to ask you to give a verbal assent for this interview. The verbal assent will signify that I have answered all of your questions and the purpose of this interview has been fully explained to you. At this time, if it is your decision to move forward with the interview, you would please state "I agree to participate."

[Wait for response; if participant agrees then continue]

Thank you very much. I would like to begin our conversation by asking you to about your background:

1. Background questions
 - a. What is your current position?
 - b. What is your current age?
 - c. How do you identify your race/ethnicity?
 - d. What is your highest level of education?
 - e. How long have you worked in this field?
 - f. How long have you been in this current work position?
 - g. Is this the only work position you've had using the Healthy Families America Curriculum? And if not, what other position(s) have you held?
 - h. What locality do you currently live in?

- i. Have you ever lived in the locality you work in, and if so when?
 - j. What is your current marital status?
 - k. Have you ever been the primary caretaker for a child?
2. Please describe your experience with the Healthy Families America program.
 - a. Probe about who are the parents and children that program is designed to reach
 - b. Probe about in positive parenting, attachment, strengths-based, and family centered practices
3. What kinds of screening does your program require you to do with your moms?
 - a. In the child(ren)?
 - b. In the parents (mother)?
 - i. Mental health
 - ii. Substance abuse
 - iii. Family violence
 - iv. Intimate partner violence
 - v. Unintended pregnancy
 - vi. Reproductive coercion
 - c. Has a mom ever discussed experiencing intimate partner violence?
 - i. How did you address this?
 1. What has worked?
 2. What did not work?
4. Please tell me about a typical day now interacting with moms?

- a. When are you seeing moms in person vs. virtual?
 - b. How do you gain trust and/or rapport with a new mom?
 - i. What personal or professional skills do you use?
 - ii. What has worked in the past?
 - iii. What did not work in the past?
 - c. How do you maintain trust and rapport throughout your relationship with your moms?
 - i. What is personal or professional skills do you use?
 - ii. What has worked in the past?
 - iii. What did not work in the past? How do you know it did not work and what did you do to repair the relationship (if applicable)?
5. Please tell me about a successful/great case
6. Please tell me about a difficult case or a time when it was hard to connect with a mom.
- a. How was this a difficult case?
 - b. What techniques did you use to address and/or overcome the challenges with this case? What worked and what did not work?
 - c. How did you utilize your supervisor's and/or other co-workers' experiences and knowledge to overcome the challenges with this case?
 - d. How did your experiences, either professional or personal, assist in working with this family?
 - e. How have you handled similar situations since that complicated case?

7. Please describe a case where it was hard for you to ask specific sensitive topic questions [if the interviewee asks for examples mention unintended pregnancy, intimate partner violence, birth control sabotage, pregnancy coercion, pregnancy outcome decision, etc.]

If interviewee discusses another sensitive topic not listed above, then steer the interview towards the above topics during a break in the conversation

- a. Some workers are finding it is easier not to ask questions about _____ at the first meeting or at every monthly meeting, how has it been for you?
- b. How were your approaches and techniques from the initial difficult case related to cases where people are experiencing these sensitive issues?
8. What formal or informal processes are in place to talk with your supervisor and/or co-workers about difficult cases experiencing sensitive issues?
- a. How does this process work with co-workers in similar positions?
- b. How does this process work with your supervisor?
9. What sort of training opportunities have you had at your job?
- a. What kind of required trainings have you had (initial or ongoing)?
- b. What other trainings have you had?
- i. Issue specific
- ii. Population specific
- iii. Technical skills acquisition

iv. Other

c. What kinds of advanced certifications/licenses do you have?

10. Can you describe the training you have received on screening for sensitive topics?

11. Is there anything else you feel I should know or any other information you would like to share?

Thank you again and please know that I really appreciate you taking time out of your day to talk with me.

Appendix G

Focus Group Question Guide

Thank you so much for your participation in the focus group interview today. As mentioned in the consent form, I am interested in learning more about how visitors approach asking difficult questions with their program participants. I am going to present the findings from individual interviews with staff members of Health Families America on screening pregnant women and new mothers. I want to hear in your impressions, reactions and feedback on these findings. I anticipate that this interview will last about 60-90 minutes. During this interview I will be using voice recording equipment as shown here. I realize that you have already signed the written formal consent form, but I'd like to take this moment to ask if you have any other questions before we get started?

[Answer Questions]

[Present the findings from the one-on-one interviews on handouts to the focus group participants]

1. Overall, how do these findings represent your experiences in Healthy Families America?
2. Overall, how do these findings differ from your experiences in Healthy Families America?
3. How do the findings represent your relationship with your supervisor?
4. How do the findings represent your relationship with your co-workers?
5. How do the findings represent your relationship with your clients?
6. How do the findings represent your experience asking clients questions about intimate partner violence?
7. How do the findings represent your experience asking clients questions about unintended pregnancy?
8. How do the findings represent your experience asking clients questions about reproductive coercion?
9. How do the findings represent your experience asking clients questions about other sensitive topics? (If participants ask for example then mention pregnancy coercion, birth control sabotage, and pregnancy outcome decision making).

Thank you again and please know that I really appreciate all of you taking time out of your day to talk with me.

Appendix H

Themes and Categories

Theme	Category	Description
Personal versus Professional Experience		
	What my training says	What participants are formally taught about their job
	Self-disclosure	Times when participants chose to talk about their own life experiences with program recipients
	What I would do	When participants gave advice to program recipients, even if it was not through a disclosure
	What drew me to the field	Discussions of what about themselves or the work that made the participant want to do the job
Therapeutic Alliance Building		
	Ways to gain trust and rapport	Specific techniques used by participants
	“Meet them where they are”	Examples of how participants meet the families where they are emotionally, readiness, etc.
	Using the curriculum	Ways the participants used the curriculum to build the therapeutic relationship
	Relationship building	Discussions of relationship building including what works and what does not work
	Creativity and flexibility	Times when participants had to use various ingenious means to keep families engaged
Keeping Families Engaged		
	“Engaging with clients has been hard”	Discussions of how engagement with families has been difficult
	Creativity and flexibility	Times when participants had to use various ingenious means to keep families engaged
	Appreciation of families and workers	When participants talked about ways they demonstrate appreciation to their co-workers and program families
	Check in with families about stress	Discussions of times when participants would check in with families regarding the stress caused by the pandemic in an effort to keep families engaged

Use of Supervision		
	Comradery within staff	Ways in which participants have connected with co-workers for informal supervision/mentoring
	Formal supervision	Statements about the setting of formal supervision (e.g., logistics, topics discussed, etc.)
	Pros and cons of supervision	What participants like and do not like about supervision
	Supervision in the time of COVID	How supervision has changed as a result of social distancing
Addressing Intimate Partner Violence/Reproductive Coercion in Families		
	Using the RAT	When participants have the used the RAT including how and when they ask the questions
	Wanted versus unwanted pregnancy	Times when participants have talked about pregnancies with program recipients in terms of wanted versus unwanted
	Relationship building in regard to IPV and RC	Discussions of relationship building to be able to better screen for violence in the home
	Creating a safety plan	Examples of when participants have done safety planning, or attempted to do, safety planning with program recipients
Home Visiting in the Time of a Health Pandemic		
	How we used to do it versus how we do it now	Discussions of how home visiting procedures have changed due to social distancing
	Positive changes during COVID	Examples of positive program changes and participant techniques that have changed due to the pandemic
	Frustrations and difficulties with all virtual	Negative emotions around program changes due to pandemic, as well as difficulties such as technology issues
	Check in with families about stress	Discussions of times when participants would check in with families regarding the stress caused by the pandemic in an effort to keep families engaged
	Supervision in the time of COVID	How supervision has changed as a result of social distancing

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