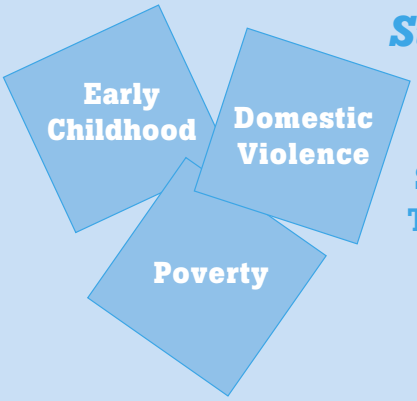
Early Childhood, Domestic Violence, and Poverty:

Helping Young Children and Their Families

Practical Guidelines and
Policy Recommendations for

- Pediatric Health Settings,
- Early Childhood Programs,
- Family Support Providers,
- Police, and
- Domestic Violence Agencies



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Dedication

This series is dedicated to the memory of Susan Schechter (1946-2004).

Susan Schechter was a visionary leader in the movement to end violence against women and children. Her work and influence were national in scope, though her home base in recent years was Iowa City, Iowa, where she served as Clinical Professor at The University of Iowa School of Social Work. Susan was a founder of the battered women's movement, and throughout her career was a respected leader and thinker in the field. She was the author or co-author of several pioneering books and monographs, including the widely cited *Women and Male Violence*, which was an early history of the battered women's movement, and the *Greenbook* that is currently the guide for many reform efforts around the country.

Perhaps Susan's most significant and enduring contribution was her path breaking and persistent effort to help the children of battered women. This work began in 1986, when Susan developed AWAKE, (Advocacy for Women and Kids in Emergencies) at Children's Hospital, Boston, which was the first program in a pediatric hospital for battered women with abused children. She also served as a consultant to several national domestic violence and child welfare initiatives and as a member of the National Advisory Council on Violence Against Women. Her analysis, writing, advocacy, and speeches played a major role in shaping current policy and practice regarding family violence and children. On a less public but no less significant stage, the positive way in which Susan touched the lives of those around her was among her greatest gifts. Susan was a remarkable person, thoughtful and good-hearted; many individuals from diverse fields were fortunate to call her a mentor and friend. Her leadership, warmth, humor, wisdom, and passionate advocacy will be missed.

This series of papers reflects the integrity of Susan's work and is a fitting tribute to her intellect and her unique skills, which bridged the fields of child advocacy and domestic violence in ways that encouraged multi-disciplinary approaches to evolve. It was her hope that this series would be a catalyst for change that would bring safety and stability to young children and families affected by domestic violence, racism and poverty.

Series Acknowledgments

I would like to thank the authors of the six papers in this series who labored diligently and generously to create sound guidance for practitioners and researchers about young children and families who are struggling with poverty and domestic violence. Their commitment was exacting and exciting: each drafted several versions of a paper, participated in two national meetings with experts from other disciplines to review the drafts, and engaged in dialogues with colleagues to refine their ideas. The authors brought an intense curiosity not only to their own work but also to that of their peers. Each deserves special thanks: Nilofer Ahsan, Associate, The Center for the Study of Social Policy; Miriam Berkman, Assistant Clinical Professor in Social Work, Yale University Child Study Center; Elena Cohen, Director, National Child Welfare Resource Center for Family-Centered Practice; Jeff Edleson, Professor, School of Social Work, University of Minnesota; Dean Esserman, Chief, Providence Police Department; Kenneth Fox, Assistant Professor of Pediatrics, Boston University School of Medicine; Abigail Gewirtz, Assistant Professor, Department of Psychology, University of Minnesota; Jane Knitzer, Acting Director, National Center for Children in Poverty; Betsy McAlister Groves, Director, Child Witness to Violence Project, Boston University Medical Center; and Resmaa Menakem, Program Director, Tubman Family Alliance.

I would also like to thank the representatives of national organizations concerned about early childhood issues who joined us to review the first drafts of the papers and offered important suggestions about their revision. They include Lois Salisbury, The David and Lucile Packard Foundation; Connie Busse, Family Support America; Janet Carter, Family Violence Prevention Fund; Bill Christeson, Fight Crime: Invest in Kids; Diane Whitehead, National Head Start Association; Susan Notkin, The Center for Community Partnerships in Child Welfare; Edna Ranck, National Association of Child Care Resource and Referral Agencies; Isa Woldeguiorguis, Domestic Violence Unit, Massachusetts Department of Social Services; Nancy Turner, International Association of Chiefs of Police; Rose Pulliam, Vermont Network Against Domestic Violence & Sexual Assault; and John Stirling, Jr., representing the American Academy of Pediatrics.

The Children's Defense Fund was a gracious and supportive host for our two national meetings, and MaryLee Allen, Director of the Child Welfare and Mental Health Division at CDF, provided her usual clear thinking and excellent planning to ensure that productive, meaningful discussions occurred.

Several experts at our first meeting also provided multicultural reviews of the papers before their final revisions. I thank Resmaa Menakem, Rose Pulliam, Isa Woldeguiorguis, and Salome Raheim, who joined our group later in its process, for their insights and gracious help to the

authors as they grappled with integrating issues of race, ethnicity, class, and culture into each paper. Catlin Fullwood and Jill Davies offered excellent meeting consultation, agenda planning, and facilitation, and Nancy Newkirk, administrative assistant at The University of Iowa, was meticulous in organizing meetings and papers. Margaret Nelson provided excellent and wise copy editing, and Beth Larsen carefully designed the papers to make them accessible and clear. I offer special thanks to Lucy Salcido Carter, former program officer at The David and Lucile Packard Foundation, for supporting this project and for her ever-present commitment to making the world better for children and families who have lived with domestic violence.

Susan Schechter, M.S.W.
Editor and Project Director

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Preface

This project began in 2001 with a grant from The David and Lucile Packard Foundation to develop a group of papers that would offer guidance to settings which work with young, low-income children who are affected by domestic violence. Papers were to be written for five organizational contexts: family support centers, early childhood programs, community police, pediatric health clinics, and domestic violence agencies. A 6th paper was to focus on the knowledge base about the impact of domestic violence on young children.

Because of an almost total lack of policy and practice guidance in the field, the project's goal was a practical one: to determine helpful interventions for community organizations serving large numbers of low-income families affected by domestic violence, in order to reduce risks and alleviate the impact of trauma on young children and their families.

Because of the complexity of linking the previously disconnected knowledge base in the areas of poverty, domestic violence, and early childhood, the papers were developed through a series of steps. First, the project director identified authors, or pairs of authors, with expertise in specific substantive areas. Authors were asked to answer these questions in their papers:

1. What does current practice in this setting offer young children affected by domestic violence? What training do staff currently receive about children's exposure to this violence?
2. What would good practice look like, given the mandates and constraints of the setting?
3. What community partners—such as domestic violence groups, legal services attorneys, or mental health providers—does the setting need in order to help these children and their families?
4. What public policies might further the work?

When the papers were completed, project staff organized a national meeting to review and refine them. This meeting in May 2002—cosponsored by the Children's Defense Fund—brought together 27 people, including the authors and representatives from national organizations, for a 2-day discussion in Washington, DC. During meeting deliberations, the authors explored the major policy and practice dilemmas that they confronted during the drafting of their documents. The participants also searched for, and identified, common principles and recommendations across early childhood settings.

These conversations proved to be incredibly rich and challenging. As expected, the meeting simultaneously advanced a common vision and generated new issues. With a second year

of grant support from The Packard Foundation, the authors had the opportunity to rethink their visions and the elements of practical advice for their fields, and also to integrate themes of poverty, race, early childhood development, family support, and violence into the papers that readers will find in this volume. The integration of these themes across diverse practice settings serving young children and their families is a first in many of these fields.

The series opens with "Helping Young Children Affected by Domestic Violence: The Role of Pediatric Health Settings," by Betsy McAlister Groves, Director of the Child Witness to Violence Project at Boston Medical Center, and Kenneth Fox, pediatrician and Assistant Professor of Pediatrics at the Boston University School of Medicine. The paper focuses on the role of pediatric health settings in identifying and intervening with young children and families affected by domestic violence. The authors suggest guidelines for screening families and discuss the many dilemmas which health providers may encounter in conducting inquiries about domestic violence. They pay particular attention to the complexities of working with child protection services and the controversy surrounding whether to interview the parent about domestic violence in the presence of a child. The paper also suggests useful interventions for children and families, including referrals to community resources and mental health services.

An important protection for young children who experience violence and other risk factors is access to high-quality early care and education programs offered in a nurturing, stimulating environment. In the 2nd paper in the series, "Young Children Living with Domestic Violence: The Role of Early Childhood Programs," Elena Cohen, Director of the National Child Welfare Resource Center for Family-Centered Practice, and Jane Knitzer, Acting Director of the National Center for Children in Poverty, provide practice and policy recommendations for helping children and families who are living with domestic violence. The authors offer practical information and resources for staff working directly with young children and their families, explore collaborations with domestic violence and other community agencies, and highlight the role that program administrators and the early childhood community can play in supporting staff and strengthening community and state partnerships.

Family support programs across the country serve thousands of families with young children. The 3rd paper in the series, "Domestic Violence and Family Support Programs: Creating Opportunities To Help Young Children and Their Families," by Nilofer Ahsan, an Associate at The Center for the Study of Social Policy, focuses on specific strategies that family support programs can use to expand their capacity to help families, especially those with young children. Drawing on examples from programs across the country, the paper offers suggestions about preparing staff members and the community to respond to violence. It is filled with tips about talking sensitively to adult victims, children, and batterers when domestic violence is revealed. The paper also suggests that family support programs

can transform larger community norms by sponsoring dialogues about violence within neighborhoods and communities. The paper concludes with policy recommendations for the field.

By virtue of their authority and their immediate presence at scenes of violence, police are in a unique position to increase security and broker services for vulnerable children and families. They can also play potentially coercive and frightening roles in addressing domestic violence and other criminal behavior. In the 4th paper in this series, "Police in the Lives of Young Children Exposed to Domestic Violence," Miriam Berkman, an Assistant Clinical Professor of Social Work at the Yale University Child Study Center, and Dean Esserman, Chief of Police in Providence, Rhode Island, sensitively delineate the many positive roles that police officers can take in the lives of families with young children affected by domestic violence and poverty. While recognizing that voluntary interventions are often preferable to criminal justice action, the authors provide police officers and administrators practical advice for responding to young children and families who are trying to cope in the midst of sometimes terrifying violence.

The 5th paper in the series, "Working With Young Children and Their Families: Recommendations for Domestic Violence Agencies and Batterer Intervention Programs," is divided into two parts. In Part I, written for shelters and other domestic violence agencies, Dr. Abigail Gewirtz, child psychologist and Clinical Assistant Professor at the University of Minnesota, proposes a developmental framework for understanding and responding to the needs of young children within domestic violence agencies. She shows how staff can facilitate critical attachment relationships between young children and their mothers, while supporting the basic principles of safety, autonomy, and choice for battered women. The paper also offers guidelines for training advocates, for screening and working with young children and their mothers, and for working collaboratively with outside providers of services for young children. In Part II of this paper Resmaa Menakem, Director of Therapeutic Services at Tubman Family Alliance in Minneapolis, focuses on the role of programs for men who batter and the possible impact of these men on children living in families experiencing domestic violence. The paper offers insights about men who batter and their parenting and helps professionals respond to domestically violent situations where children are present.

In the final paper in the series, "Young Children's Exposure to Domestic Violence: Toward a Developmental Risk and Resilience Framework for Research and Intervention," Abigail Gewirtz, child psychologist and Assistant Clinical Professor at the University of Minnesota, and Jeffrey Edleson, Professor at the University of Minnesota School of Social Work, conclude the volume with a look at the research. The authors employ a developmental risk and resilience framework to review studies and examine the impact on young children of exposure to adult domestic violence, particularly for those families facing economic hardship. In doing so, the paper expertly weaves together two separate literatures, one on child development in high-

risk settings and the other on children exposed to adult domestic violence. The paper points to the promise that early interventions hold for helping children who are living in poverty and exposed to adult domestic violence, and concludes with a call for further research to move our understanding forward.

It is hoped that practitioners will use this volume to learn more about effective services in their own settings and, stretching beyond their work environment, they will also review the other papers in the series and be inspired to engage other community partners in responding to and ending domestic violence in the lives of low-income children and families.

Susan Schechter
Editor and Project Director

Early Childhood, Domestic Violence, and Poverty: Helping Young Children and Their Families

Series Introduction

Introduction

This series of papers addresses a widespread but often hidden challenge: how to mobilize community and programmatic resources to provide responsive help to young children and families affected by both domestic violence and poverty. The challenge is broad and complex. Although these children and families come into contact with many helping systems, their problems with violence are often invisible, and the assistance that they need is therefore unavailable, uncoordinated, or unresponsive to specific family or cultural contexts.

The six papers in this series are designed to offer practical guidance to organizations that encounter and help these families. They were specifically developed for community-based agencies working with families that confront family violence along with the multiple difficulties linked to poverty, such as inadequate income for healthcare or childcare, lack of affordable housing, immigration problems, and/or family stress exacerbated by poverty. They recognize that, compounding the stresses and lack of options that poverty imposes, domestic violence adds yet another burden for families.

The series aims to knit together two agendas, addressing domestic violence and promoting healthy development in young children affected by it. The overall goal is to engage the intervention network of pediatric health care professionals, childcare providers, family support workers, community police officers, and domestic violence advocates, in order to help families find safety and stability before repeated trauma takes its toll. Early and effective intervention and support may prevent families and children from encounters with more coercive systems, such as child protective services and the courts. By effectively mobilizing the resources of community agencies, concerned neighbors, and kin, and by building on the strengths and carefully crafted survival strategies of battered women, this intervention network can promote children's healthy development and literally save lives.

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Why Focus on Young Children As Part of a Domestic Violence Agenda

Over many years, advocates, researchers, and professionals have raised significant concerns about the impact of poverty on young children and families. Although research suggests that many low-income young children and their families are resilient in the face of economic insecurity and hardship, for substantial numbers the toll is great. For young children, this toll is reflected in social, emotional, behavioral, and cognitive outcomes that put them at a disadvantage in comparison with their more affluent peers. Nine million children—just under 40 percent of all children under six—are growing up in families with incomes under 200 percent of the poverty level; 4 million of these children officially live in poverty and 5 million live in near poverty (Song & Lu, 2002). Children of color and their families bear a disproportionately heavy burden. Their poverty rate is about three times as high as the rate for white children and families. Research is consistent that poverty is the greatest risk factor for children's development: for example, in comparison to their more affluent peers, young children in poverty typically do worse on virtually all indicators of school readiness (Zill & West, 2001).

For those young children who experience economic risks and adverse family circumstances—particularly domestic violence, substance abuse, or maternal depression—the possibility of negative outcomes is heightened. These risk factors, either singly or in combination, disproportionately affect low-income adults, particularly women. A synthesis of research on more vulnerable families finds that although some children do well, many others show some combination of attachment problems (especially for infants and toddlers), developmental delays, learning disabilities, symptoms of post-traumatic stress disorder, difficulty in peer and other caregiver relationships, and later vulnerability to alcohol, tobacco, drugs and substance abuse (Knitzer, 2000).

The literature which specifically focuses on the impact of violence on children begins to tell an even more nuanced story. Although much remains to be learned, it is already clear that many young children live in families where their mothers are abused. For example, in a study of police response to 2,400 adult victims of misdemeanor domestic assault in five U.S. cities, more than 80% of the affected households included children; almost half had children under 5 years old (Fantuzzo et al., 1991). A study of Head Start families found that 17 percent of parents report that their children have been exposed to domestic violence, and 3 percent of their children have been abused (Zill, Reznick, & McKey, 1999). There is also an intergenerational aspect to the problem. In the last 20 years, the majority of studies have found that between 30 and 60 percent of the children of abused women are themselves maltreated, often by the men who are assaulting their mothers (Edleson, 1999). To make matters even more difficult, some of the children who are exposed to violence at home also witness it on the streets of their communities.

Young children respond to this exposure to violence in very diverse ways. In fact, research suggests that the impact is enormously varied. Children who repeatedly witness violence against a parent—and who are themselves abused, as well—seem to bear the worst consequences. Teachers,

for example, see the repetition of traumatic violence in their play, and pediatricians notice their loss of developmental progress. Still other children are repeatedly aggressive with their peers, and sometimes withdrawn and depressed (Osofsky, 1997). While numbers of children show these distressing effects, many others are quite resilient. Much of the research points to the importance of effective and caring parents in alleviating harm (Edleson, Mbilinyi, & Shetty, 2003; Holden, Stein, Ritchie, Harris, & Jouriles, 1998; Levendosky, Lynch, & Graham-Bermann, 2000; Sullivan, Nguyen, Allen, Bybee, & Juras, 2000). It also highlights the positive impact of early family and child interventions (Jenkins & Bell, 1997).

Although many interventions have been designed to support families living in poverty, to protect children who are abused and neglected, and to help families affected by domestic violence, these interventions remain basically separate and deeply fragmented. Unfortunately, in many communities parents are still forced to go from one agency to another as they try to meet their material needs and find help for their children or safety for themselves. Families, however, do not experience their needs one at a time. The papers in this series are designed to make it easier for families by offering early childhood community-based providers a common approach to the work and an understanding of the other systems and agencies in their communities that families use as they seek safety and stability. They also send a message that there are alternative, safe ways of helping young children and families without resorting to out-of-home placement, even as there surely are circumstances when such placements are vital.

These papers were drafted by collaborating pairs of practitioners and academics who are experts in domestic violence and early childhood interventions within health, childcare, family support, and law enforcement settings. Each paper was reviewed in May 2002 at a meeting of authors and staff from national early childhood and domestic violence organizations. The meeting stimulated the participants to look beyond their own disciplines and across institutional boundaries. Participants challenged each other to think about how poverty, race, and ethnicity interact to affect communities and individuals experiencing violence. The group returned repeatedly to the theme of the often insurmountable barriers that institutions impose on low-income families. It offered almost unanimous support for early childhood interventions and for breaking down narrowly defined and categorical funding for services. At the programmatic level, participants searched for ways to protect women and children while at the same time reaching men who batter before violence escalates. But they also recognized the need to engage the broader community in helping to protect and ensure the safety of women and children by strengthening not just formal, but also informal, supports.

The papers in this series focus on practice interventions that can be implemented in the context of service delivery, but participants at the meeting repeatedly emphasized the importance of developing a continuum of responses to violence and poverty: they articulated the need for prevention strategies; for early interventions such as home visiting approaches; and for treatment aimed at those already experiencing violence. They also recognized the need for broader change to address social inequalities. During the two-day discussion, participants initiated a cross-

disciplinary dialogue which urgently needs to be mirrored at national, state, and local levels as communities try to overcome fragmented responses to children and families. During the meeting deliberations, the participants also articulated a set of principles for local and national activities developed on behalf of young children and families struggling with domestic violence and poverty. This framework is reviewed below.

Establishing A Common Practice Framework for Work in Early Childhood, Domestic Violence, and Poverty

Poverty clearly affects the incidence of domestic violence: low-income women are more than 2.5 times more likely to be abused than their higher income counterparts (Jenkins, 2003). Although the recent National Violence Against Women Survey, a representative sample of 8,000 women and 8,000 men, found that rates of violence differ among ethnic groups—for example, 15% of Asian and Pacific Islander women reported physical and sexual assault or stalking during their lifetimes, while 24.8% of white women, 37.5% of Native American and Alaskan Native women, and 29% of African American women did—most studies suggest that these racial/ethnic differences can be largely explained by income. Researchers highlight the fact that low-income men who batter are much more likely to face multiple stressors such as unemployment, racial discrimination, or the loss of status due to immigration.

All low-income families struggle with limited material resources and related hardships. But families struggling with domestic violence and poverty are likely to have more needs than other families: battered women and their children may require protection; men who batter may find themselves facing legal and social service interventions; families will need increased economic resources to survive, and children will require financial stability and emotional comfort. All those who work directly with children and families affected by poverty and domestic violence need to be responsive to these circumstances as well as to the cultural ways in which family members define and most comfortably solve problems. Further, although no single community agency can provide a comprehensive array of the needed responses, collectively, communities can embrace a common vision and work together, across institutional boundaries, to implement this vision as fully as possible. This vision includes the following five elements of a common practice framework.

1. Young children and their caregivers need to be safe.

Domestic violence is a pattern of assaultive and coercive behaviors—including physical, sexual, and psychological attacks, and economic coercion—that an adult uses against an intimate partner. This pattern of serious assault is most typically exercised by men against a female partner and sometimes against their children.[1] These assaults are often repetitive and continuous and may leave women and children feeling dazed and bereft.

[1]Because the most serious forms of adult domestic violence are carried out by husbands and male partners, the term "battered woman" is used in this series to refer to the adult victim. However, lesbians and heterosexual and homosexual males are also victims of the kind of abuse described in the series.

In the face of abuse and assaults, a battered woman with children often confronts two kinds of difficult decisions. First, how will she protect herself and her children from the physical dangers posed by her partner? Sometimes, however, a second kind of risk threatens her more: how will she provide for her children? If, for example, a woman decides to leave her partner to protect herself and her children, where will she find housing and money to feed her family? Who will take care of the children if she must work and her partner is no longer there? This second set of social and economic risks is central to each battered woman's calculation of her children's safety. Leaving her relationship does not guarantee the elimination of these risks; in fact, it may make them worse (Davies, Lyon, & Monti-Catania, 1998; National Council of Juvenile and Family Court Judges, 1999).

For women who have immigrated to the United States, these life-generated risks are often further complicated, especially if their families are poor. What will they do if they have no access to governmental benefits such as welfare or food stamps? What if they cannot speak English, are without money, and in physical danger? Will authorities care about them or their children, or will their families experience discriminatory treatment when they seek help? And what will the authorities do to their partners (National Council of Juvenile and Family Court Judges, 1999)? In addition, many immigrant women and women of color fear ostracism from their own communities if they speak up about the violence, seek help to stop it, or expose their partners to potentially damaging interventions by the police or courts.

Many people frequently raise the question, "Why do battered women stay in their relationships when abuse places them and their children in harm's way?" This question reflects a misunderstanding of the way abused women weigh risks and make decisions. Battered women's questions are more thoughtful and complete, such as the following: "If I leave, will my partner get so angry that he will kill me and the children?" "Should I leave and make my kids live in poverty or in a more dangerous neighborhood?" (National Council of Juvenile and Family Court Judges, 1999). "Will my children ever see their father again if I call the police or go to court for my own protection?" "What should I do if I want them to have a relationship with their father?"

Most battered women care deeply about their children's safety and try to protect them from physical assaults and from poverty (National Council of Juvenile and Family Court Judges, 1999). In the face of ongoing fear and threats, many women try valiantly to shield their children during attacks and to nurture them in their aftermath. They also plan strategies to help their partner stop the violence—they reason with him, ask family members to talk to him, call the police, request a clergyman's help—yet their strategies are not always successful. Creating safety requires that communities also try to eliminate the two sets of risks—physical and material—that children and their mothers face. In fact, children's safety and security are often dependent on making their mother safe.

At the same time, it is also important to recognize the complexity of family relationships, and that in many families the ties to the batterer continue. Over the last twenty-five years, communities

across the United States have developed a combination of legal sanctions and social services, such as batterer intervention projects, to try to simultaneously insure that men who batter are held responsible for harming family members and that they receive help for stopping the behavior. Increasingly, community providers are being urged to pay attention to the man who batters and to work collaboratively across agencies so that he, and not his partner, is held responsible for the effects of violence on children, and so that he receives timely interventions to change.

2. Young children need to experience warm, supportive, nurturing relationships with their parents and with other caregivers.

According to a recent and remarkable synthesis of developmental and neuroscientific literature, the earliest relationships between young children and those who are closest to them provide the "active ingredients" for how children develop emotionally and cognitively (Shonkoff & Phillips, 2000). This report makes it clear that those who provide primary care to young children have an especially potent influence on their early development. Using data about both early brain and psychological development, the research shows how, through these earliest relationships, young children learn to trust others, to manage emotions, and to explore their worlds in positive ways. It also cautions that the early years can be a time of vulnerability, particularly for young children exposed to poverty and other risk factors. For these children, the research is clear that the more demographic and psychosocial risk factors to which they are exposed, the more likely it is that their development will be compromised.

These findings underscore the importance of community providers in supporting a child's primary caregivers, usually the mother and other family members, as they try to build healthy and strong relationships with the child. The people with whom the child has the closest relationships are often, although not always, in the best position to help the child cope with difficult experiences. But those closest to the child are likely to need assistance in knowing how best to do this. Childcare providers, pediatricians, family workers, and children's advocates are all in a position to help parents and others understand how important they are to their children and how best to support them. When community providers ensure that parents have access to these supports, they are creating building-blocks for strong and healthy relationships between parents and their young children. Community providers also are key to ensuring that young children have age-appropriate opportunities outside the family. These experiences matter: their impact is obvious in the young child whose vocabulary rapidly expands in the context of a well-run shelter childcare program, or in the infant and parents whose relationship turns a corner and starts to thrive with the support of an Early Head Start program.

3. Young children and their families need to have their basic needs met.

Common sense tells us that poverty and economic hardship (e.g., being hungry, or homeless) are not good for people in general and children in particular. Research tells an even more compelling story. Poverty, as suggested earlier, contributes to a wide range of negative outcomes for children. But research also suggests that the timing and depth of poverty make a difference. Poverty in

early childhood, for example, appears to be more harmful than poverty at other ages, particularly in terms of cognitive development (Duncan, Yeung, Brooks-Dunn, & Smith, 1998). Research is also deepening the understanding about the impact of changes in family income on child development. For example, research suggests that when family income increases, controlling for any other changes, young children's performance on social, emotional, and cognitive indicators improves (Dearing, McCartney, & Taylor, 2001).

In trying to understand the impact of income on developmental outcomes, researchers are focusing on two explanations (Cauthen, 2002). First, poverty limits financial investments that parents can make in their children—both to meet basic needs and to create an enriched learning environment. Second, inadequate material resources may create higher levels of stress and even depression in parents that in turn affect their parenting behaviors in negative ways (Yeung, Linver, & Brooks-Gunn, 2002). Those working with young children and families cannot solve the problems of poverty, but they are in a position to ensure that both caregiving and non-caregiving parents have access to all benefits to which they are entitled, as well as to local opportunities that will promote their economic security. Focusing on financial strategies can help ensure that women and children are not trapped in violence because of their economic circumstances. Similarly, focusing on economic issues with men who batter may also have a positive impact, particularly on domestic violence recidivism rates, which are highest among those who are unemployed.

4. **Young children and families need to encounter service systems that are welcoming and culturally respectful, and service providers with the cultural knowledge, skills, and attitudes to help them.**

Although the majority of poor families in the United States are white, the United States is now a country with many diverse communities of color. In fact, over the last several decades, the United States has become a country with an ever-increasing mix of cultures. The U.S. Census 2000[2] revealed that more than 12% of respondents reported their race as Black or African American; an additional 12% reported themselves as Hispanic; 1% described themselves as American Indian or Alaskan Native; and almost 4% categorized themselves as Asian or Pacific Islander. Obviously, the differences within individual racial and ethnic groups are also many. Over 40 ethnic groups are represented in the Asian and Pacific Islander population, with many of them—Chinese, Japanese, and Filipino populations, for example—having lived in this country for generations, and others, such as the Hmong, Laotian, and Vietnamese, arriving more recently and bearing burdens due to displacement and war. The differences in income, educational attainment, language proficiency, and immigration status are enormous within this population (Yoshihama, 2003). The same is true for Latinos in the United States, who come from over 20 Latin American, Caribbean, and European countries.

[2]The U.S. Census 2000 used revised standards for collecting data on race and ethnicity wherein respondents could record more than one race.

Although the psychological consequences of domestic violence seem to be similar for all women (Jenkins, 2003), victims from different races and ethnic groups may explain and experience battering in very different ways. For example, some Southeast Asian women may be abused not only by their husbands but also by their in-laws and other extended family members. These women may need help to deal with multiple abusers. The help or services that women prefer may also vary considerably across ethnic and racial groups and even within them. Because African American women and Latinas understand discrimination first-hand, their explanations and solutions for their partners' violence may include removing structural barriers for the men, such as unemployment and harsh criminal justice responses (Jenkins, 2003; Perilla, 2003). In this regard, they may be similar to other groups of women of color who, facing family violence, want to protect themselves and their communities from outside criticism and build interventions for the entire family. For women who are in the United States illegally or whose immigration status depends on a United States citizen, calling the police for protection may lead to loss of their status, deportation, or incarceration. Hence, helping these women and their children is even more complex than in some other circumstances.

What all women share is that, as they seek assistance, individuals also want to feel respect and support for their ethnic traditions and cultural values as well as for other significant aspects of themselves, such as their sexual orientation. Interventions need to support and use the cultural framework of clients without unwittingly encouraging women to endure abuse. For example, some women will seek services only if they know that their children and partner will also receive help. Other women may prefer that no one in their community or family know about their help seeking. For still other women the idea of seeking shelter or leaving their partner is an unimaginable proposition, but they do want to be safe. Yet, for still other women, calling the police to stop an assault or warn an abuser may be exactly what they want. These differences highlight the need to support a range of responses and individualized solutions to domestic violence, while at the same time understanding larger cultural patterns.

From a community provider perspective, the ethnic and cultural diversity of families facing poverty and domestic violence poses significant challenges. Staff that look like the families, speak their language, understand their spiritual and cultural background, and can talk about safety with an appreciation for the complexities of those conversations can make a big difference, but even agencies that do not have this can become more responsive. However, it requires a commitment. To do this multicultural work well, agencies must carry out a careful assessment of their mission, policies, hiring procedures, services, staff supervision, budgets, and resources that are provided for training in cultural competence. Above all, they must be prepared to learn from their resourceful clients.

5. **Young children and their families should be able to receive early, strengths-based interventions to help them avoid the harmful consequences of domestic violence and to reduce the likelihood of entry into the child protection and, ultimately, juvenile court systems.**

Emerging developmental knowledge makes a strong case for early intervention that helps children and families experiencing multiple risk factors. Adults need assistance in meeting safety and basic needs. Some adults may also need help to repair or prevent damaged parent-child relationships and to promote positive parenting. Children need access to health care, developmental screening, high-quality early childhood programs, and, if necessary, specialized services (Knitzer, 2000). Recent research findings on specialized interventions for children who have experienced domestic violence are promising. A review of the findings from 15 projects showed that children who participated in groups or in mother-child dyadic interventions showed significant gains: these children reduced their use of aggressive behaviors, experienced a decrease in their anxious and depressive behaviors, and improved their social relationships with peers (Graham-Bermann, 2001).

Strengthening the focus on early intervention for young vulnerable children and their families is especially critical because, in the absence of specific attention to early intervention services, community providers are more likely to believe that their only alternative, and/or obligation, is to refer a family experiencing domestic violence to Child Protective Services (CPS) or to the police. Such referrals become the default option. CPS certainly has an important role to play for those children at serious risk of harm. If Child Protective Services, however, is the only assistance available, many families will avoid seeking services, fearful that their disclosure of violence will lead to removal of their children.

Although most reports to CPS do not end in removal, reports to protective services have skyrocketed in recent decades, and the number of children in foster care has doubled in the past twenty years. Infants and toddlers now comprise the fastest growing age group in the child welfare population. Fears of CPS involvement are especially pronounced in communities of color. For example, Native American families have a long history of losing their children to boarding schools and to white families. African American children currently make up nearly one-half of the foster care population, although they constitute less than one-fifth of the nation's children. The racial disparity in outcomes—African American children, for example, also spend much more time in foster care than other children—creates great pain for families as well as distrust and suspicion of public agencies (Roberts, 2002). Therefore, responsive early interventions that can prevent unnecessary placement have powerful, long-range, and positive consequences.

Similar fears are voiced about the involvement of the criminal justice system, although many low-income women use this system to protect themselves and their children. A recent review of the issues facing Asian and Pacific Islander battered women points to their reluctance to report their victimization to the authorities because they fear insensitive treatment and because they do not

wish to subject their partners to discrimination by social institutions (Yoshihama, 2003). These concerns about protecting men from systemic discriminatory treatment are similar to those voiced in the African American community, where almost 13 percent of Black men between the ages of 25 and 29 are in prison or jail on any given day (Harrison & Karberg, 2003). Although the police, courts, and child protective services can be life-saving for battered women and their children, many families are also torn about using them. The development of earlier interventions for domestic violence and poverty at various locations within a community, and of a more comprehensive continuum of responses, would create far more safety alternatives for families and help them avoid involvement in more coercive systems.

Practice Implications

Together, the five principles just highlighted define a common framework for community-based interventions on behalf of families with young children facing poverty and domestic violence. However, making these principles live in the real world is a challenge to those who work directly with families, to community agencies, and to the broader community.

Recommendations for Those Who Work Directly with Children and Families

The challenge is particularly acute for those who work directly with the children and families. Many community-based providers do not yet know how—or if—to offer help to families experiencing domestic violence. Often providers are unclear about their role and afraid that they may be prying into private and family matters. Cultural differences may increase providers' discomfort and discourage them from exploring sensitive issues. The adult women whom they help may appear strong and easily insulted by an inquiry about their safety. Workers also may feel anxious about their personal safety and feel inadequate about their intervention skills. Some workers involved with the families are themselves current or former victims of abuse, and they may be especially reluctant to open up these issues.

Yet families need agencies with staff willing to talk about and respond to violence. Many abused women will seek out domestic violence services only after assaults have escalated to serious levels, after they have been unsuccessful in getting help from those closest to them. If community providers can intervene earlier, they have the opportunity to avert further violence, disruptive moves, and other major losses for the family. Earlier interventions for men who batter, before violence has escalated, can also lead to better outcomes (Edleson, 2000) and may help those women who want to stay with their partners, free from the fear of assault.

Child development knowledge is also essential for an effective community intervention network. Some staff who come into contact with young children may not know the warning signs that indicate that development is off course. Or, they may not know what kinds of services are available and helpful. Both best-practice knowledge and some research suggest that parenting supports, developmental services for the children, and case management—ensuring that families are receiving all possible benefits—are critical to promoting healthy outcomes for young children.

How then does the provider approach the family with a young child in which domestic violence is suspected? Although each paper in this volume offers additional concrete guidance for specific settings, our expert panel of authors and reviewers developed a consensus about the best ways to reach out to the family in the hope that its members will accept help. The approach includes the following recommendations:

1. *Build a relationship between the provider and the family member as a way to inquire about violence and safety.*
2. *Demonstrate active concern about the adult victim and batterer while always conveying that the abuser is responsible for stopping the violence.*
3. *Be aware that domestic violence encompasses a wide range of behaviors, from pushing and shoving to life-threatening danger, and requires differential interventions by the community.*
4. *Preserve and promote the attachment between the child and the immediate and extended family and other caregivers, whenever possible. Also recognize that some children will have ongoing relationships with fathers who have battered without experiencing further harm. For other children, however, the contact will be too dangerous, and for still others, it will need to be supervised.*
5. *Appreciate that the parent is most often the primary pathway to protecting the child and helping the child successfully deal with trauma. Also be aware, however, that parents need support and help in doing this.*
6. *Use strengths-based approaches to the family that acknowledge the many strategies women use to keep themselves and their children safe.*
7. *Help individual family members to meet a range of material, safety, and emotional needs.*
8. *Help families identify warning signs that development is off track and follow up to ensure that young children get help for any developmental or relationship problems.*
9. *Appreciate and acknowledge the cultural context and values of the family.*

Recommendations for Interagency Practice

Because of the complexity of providing help to families with many needs, a consensus among our meeting experts also emerged about the necessity of interagency collaborations. Families' needs will not be met unless community agencies learn to work together, share common goals and practices, and help their workers jointly develop skills to assist those who are struggling with complex issues such as violence, substance abuse, mental illness, and poverty.

Recommendations for interagency practice include the following:

1. ***Choose the least coercive interventions to maintain safety, whenever possible, and use those that the family will find most helpful.***

2. ***Develop a continuum of community responses to meet safety needs, ranging from the voluntary through the mandatory, such as Child Protective Services. This will require the expansion of a community system of care, with multiple entry points for help to families experiencing domestic violence and poverty (National Council of Juvenile and Family Court Judges, 1999).***

3. ***Build the capacity of informal supports and non-stigmatized settings to respond to families experiencing violence. Civic, religious, and spiritual leaders can all play a role.***

4. ***Collaborate actively and consistently with other agencies to get help to families experiencing violence, substance abuse, and mental health problems, and with economic, immigration, and other needs.***

5. ***Provide or find advocates for families as they work with multiple systems.***

6. ***Support the safety and well-being of agency staff and volunteers. Ensure adequate staff pay and benefits, as well as providing supervision, training, and consultation.***

7. ***Work collaboratively across agencies to develop prevention strategies, such as public education campaigns and neighborhood forums, to promote community norms that build respectful relationships and challenge family and community violence.***

Conclusion

This series is a call to action for those who work directly with children and families and for interagency collaboration. But the participants at the meeting also addressed an even greater challenge: building a common vision and engaging leaders from all parts of the community to reduce levels of violence and the isolation of families facing harm from domestic violence. To that end, some of the papers in the series discuss community-wide infrastructure building, strategic planning, and collaborations, as well as the policies necessary to support new practices.

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Early Childhood
Domestic Violence
Poverty

Helping Young Children Affected By Domestic Violence: The Role of Pediatric Health Settings

Series Paper #1

Introduction

A pediatrician in a busy community health center in Boston reported the following case:

> A six-year-old Puerto Rican boy came to the clinic with his mother, whose chief concern was that his medication for Attention Deficit Disorder "doesn't seem to work anymore." According to the mother, Juanito was a good student last year, but is doing poorly now. He fails to complete schoolwork and is disruptive in class. The family has moved frequently in the past two years. Recent chart notes indicate that the Department of Social Services investigated the family three months ago. When the pediatrician asks if the mother feels safe in her current living situation, she replies that she "feels safe now," but her eyes fill with tears.
>
> She then asked if Juanito could wait in another room and told the pediatrician the following story:
>
> *"Four years ago, when Juanito was two and I was about to have the new baby, I had finally decided to leave his father. I had told my mother-in-law. That was a mistake. I thought she was on my side, but she said it was my responsibility as a wife to stay. 'You think life is supposed to be easy for a woman?' She cussed me out. Bad.*
>
> *"So on the day I was going to go to the shelter, Juanito's father came home early from work. He said he was hungry, could I fix his plate? He was watching TV, lit a blunt (marijuana), and then I heard this crash. I tell you it was like hell busted loose, like a dam burst all through my house.*
>
> *"Juanito's father came in the kitchen and started kissing me real hard. Then he bit my tongue and wouldn't let it go. It started bleeding. The pot boiled over. Soup splashed on the floor. Juanito started crying. I put Juanito in his room and closed the door.*
>
> *"My husband broke everything that night. He said he didn't think I would be needing this and that anymore. He broke the front room window with*

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the dining room chairs I had just got out of lay-away. He cut up the curtains and pulled the stuffing out of the couch and the tape out of every cassette. He broke all the dishes and glasses in the cabinets, the baby's bassinet, the bathroom mirror, and the hands on the kitchen clock. He ripped open the bird cage and broke the parakeet's wing with a broom when it tried to fly. He knocked it all up against the wall.

"Then he said it was all my fault because I had burnt his food. That he doesn't have money to throw away food like that. That I better clean it up. That I was a 'dinner-burning whore' and all that. He dumped everything out of my purse on the floor and crushed it. He broke my red lipstick. Then he said he was going out for Chinese food. Did I want something?

"Juanito didn't see all that, and anyway he was only two, and I had closed his bedroom door. But when I went in his room that night, he was in the closet. When I tried to get him out, he slapped me dead in the face. That hurt even though his hand was small. Later, we left his dad."

The pediatrician replied, *"I'm so glad you made it here today. Children who see too much react in many different ways. It sounds like you might be worried that this has affected Juanito as he has gotten older. You are a very strong person and you've taken some big steps to put your life back together again. If you'd like me to, I will refer you and Juanito to a special counselor in a program that works with young children who have witnessed violence in their home. But I have two questions for you:*

"Are you safe? How can we keep you and Juanito safe? I'm asking you these questions because there may be other resources—social, economic, and legal—we can use to support the important steps you've already taken."

After a soft knock, Juanito slipped in and sat on his mother's lap. *"Did you color this house for me?"* his mother asked. He nodded yes.

"Que linda! Mommy loves you, too. I need to talk to the doctor to make a plan. I will be out in a minute, Juanito. Promise." She wiped her eyes and hugged him tight.

This case demonstrates the importance of routine inquiry about safety and domestic violence in a pediatric setting. Had this doctor failed to ask about safety, one wonders if he would have learned this powerful and important information about his patient's history. Because the mother trusted her pediatrician, she could tell him about her experiences, and the doctor could connect the dots and voice his concern about the long-term impact of this traumatic violence on her son. The pediatrician's role was to make certain that this boy's history of trauma was recognized and that he received adequate support. As is evident in this case, pediatric health settings play a crucial role in identifying and supporting families affected by domestic violence.

In 1998, the American Academy of Pediatrics recognized the significance of domestic violence by publishing a position statement entitled *The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women* (American Academy of Pediatrics, 1998). The first

sentence of that statement was, "The abuse of women is a pediatric issue." One of the Academy's recommendations was that "pediatricians should attempt to recognize evidence of family or intimate partner violence in the office setting" (see http://www.aap.org/policy/re9748.html). Although the statement made a strong case for identifying domestic violence, it stopped short of offering specific guidelines for screening and did not provide discussion about the policy and practice dilemmas that arise when pediatric providers implement screening protocols for family violence. Since then, a number of studies have focused on screening in pediatric settings. In 2001, the Family Violence Prevention Fund convened national experts to develop additional guidance for screening in pediatric and family practice settings. These recommendations were published in 2002 (Groves, Augustyn, Lee, & Sawires, 2002).

This paper will highlight the importance of the pediatric health setting in working with young children affected by domestic violence and will provide a review of research on screening in pediatric settings. It will elaborate on the practice and policy dilemmas that pediatric health providers face. A specific emphasis will be placed on mental health services as resources for pediatric providers, clarifying when to refer young children for mental health care; the characteristics of good mental health services; and the limitations of the current response. Finally, the paper will propose policy recommendations for improved practice in pediatric health and mental health settings.

Children, Domestic Violence, and Health Settings

There are over 100 studies that have explored the effects of domestic violence on children (Edleson, 1999a). Most of these studies have focused on latency age children or adolescents. These studies generally have not examined race or culture as a protective or risk factor. In addition, there is little systematic research on the effects of exposure to domestic violence on infants, toddlers, and pre-schoolers. (For a discussion on the gaps in the research, see Series Paper #6—*Young Children's Exposure to Adult Domestic Violence: Toward a Developmental Risk and Resilience Framework for Research and Intervention*, by Abigail Gewirtz and Jeffrey L. Edleson.) However, clinical findings from the Child Witness to Violence Project at Boston Medical Center, described later in this paper, suggest that young children are profoundly affected by growing up in homes where there is domestic violence (Groves, Acker, & Hennessey, 2002). As early as age two, these children may suffer from symptoms of increased arousal as evidenced by sleep problems, impulsivity, exaggerated startle responses, and hypervigilance (Scheeringa & Zeanah, 1995). Many of these children are aggressive and highly active. Children who grow up in homes where there is domestic violence are also more likely to be victimized or to experience child abuse and neglect. In 30 to 60 percent of families affected by domestic violence (depending on the study), children are directly abused (Edleson, 1999b). Young children are more likely to be abused than older children, often because they cannot get out of harm's way.

Pediatric health settings are perhaps the only institutions that see virtually all children at some point in their early years. As such, these settings provide a critical opportunity to screen families

for social and health risks. In addition, pediatricians are viewed by most parents as important and respected authority figures. Their inquiry about family violence communicates a strong message about their concern for this problem. Pediatricians can use their positive authority to educate parents about the impact of exposure to violence.

Several studies make a strong case for the importance of providing screening for domestic violence in pediatric settings, especially in low-income communities. The Adverse Childhood Experiences Study, conducted on a sample of 30,000 members of the Kaiser Health Plan in California, selected exposure to violence against a mother as one of seven risk factors to be investigated for later adult health problems (Felitti et al., 1998). In this study, 12.5% of respondents reported childhood exposure to domestic violence, and 10.8% indicated a history of child abuse. This study underscored the prevalence of exposure to domestic violence in a large non-clinical sample, and linked this exposure to adverse adult health outcomes. Another study, conducted in five major US cities, found that young children—ages five and under—were disproportionately represented in households where there was substantiated domestic violence, and that a sizable number of children were directly involved with the abuse incident by either calling for help, being identified as the cause of the dispute that led to violence, or being directly physically abused by the perpetrator (Fantuzzo, Boruch, & Beriama, 1997). A third study, sampling families who used outpatient pediatric health services in an urban hospital serving low income families, focused on prevalence of exposure to violence in children age six and under, using reports from parents (Taylor, Zuckerman, Harik, & Groves, 1994). Researchers found that 10% of the children had witnessed a knifing or shooting by the age of six, and an additional 18% had witnessed "pushing, kicking, hitting, or shoving." Parents reported that nearly half the violence their children had witnessed occurred in the home. A fourth study, conducted in an urban outpatient pediatric clinic serving low-income families, found that 40% of a sample of 160 mothers had filed a restraining order against a boyfriend or husband (Lenares et al., 1999).

Two studies have drawn from samples of patients in middle class or affluent areas and found lower rates of domestic violence disclosures. One study focused on a pediatric practice in which the majority of mothers had private insurance and found that 17% of mothers reported domestic abuse (Parkinson, Adams, & Emerling, 2001). Another study, involving multiple sites, implemented a standardized set of screening questions for four practice groups. It found a range of rates of reported current abuse: 6% in a practice with Medicaid or uninsured patients; no disclosures in a more affluent private practice (Siegel et al., 2001).

Together, these studies lead to several conclusions: first, that domestic violence is present in many families; second, that domestic violence is more likely in communities that are characterized by impoverishment and high crime; and third, that young children are disproportionately represented in families where there is domestic violence. These conclusions point to a compelling opportunity within pediatric practice to identify and assist young children who may be living with domestic violence.

Domestic violence is one among many threats to child health and development, particularly in contexts marked by poverty and economic inequity. Poverty, at the start of the 21st century, remains the single most powerful predictor of child health outcomes (Wise & Fox, in press). Poverty may act as an independent force in the generation of poor health outcomes or combine with other large-scale social forces like social marginalization (unjust exclusion from essential resources on the basis, for example, of racial, ethnic, linguistic, or gender identity) to achieve its health-harming consequences (Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001).

Poverty represents more than inevitable misfortune randomly distributed among a luckless few. Its effects on health, now well-documented, are cumulative, pervasive, and persistent at points all along the life course. Poverty places children in an awful position called "double jeopardy"—they suffer both elevated risk that health problems will occur and greater likelihood of harm once these problems do occur (Parker, Greer, & Zuckerman, 1988).

Insurance status in the U.S. is a critical predictor of whether health care happens at all (Newacheck, Hughes, & Cisternas, 1995), and almost 11 million U.S. children are uninsured (Children's Defense Fund, 2001). Poor children are less likely to be insured than non-poor children. In addition, racial/ethnic inequities in insurance coverage are stark: one of six Black children and one of four Latino children is uninsured, compared with one of eleven White children. For these reasons, poor and minority children are also less likely to have a medical home—a regular source of primary medical care (Cornelius, 1993). These social facts have profound impact on pediatric health and care among the poor. Discontinuities in care entailed by the absence of a medical home also exacerbate poor kids' double jeopardy (Halfon & Newacheck, 1993) and lower the quality of care they receive. Moreover, poor families may not be able to afford co-payments for medications, medical equipment, or doctor's office visits. Poor children have less preventive care, anticipatory guidance, safety information, and phone consultation. Unfortunately, those at greatest risk for poor health outcomes also have the least access to high quality health care (Wise and Fox, in press).

In sum, inadequate material and social resources, diminished access to care, and disruptions in continuity of care heighten poor children's risks for harm from domestic violence. Existing vulnerabilities thus cluster to enhance the threats posed by domestic violence.

Practice in Pediatric Settings

Currently, there are no guidelines that have been endorsed by the major professional medical associations for screening for domestic violence in a pediatric health setting. In practice there are a number of protocols for screening, although their use is erratic. In some settings, questions about safety and domestic violence may be asked on written forms. In others, providers use computer-based prompts to question patients. In still others, the provider screens patients with a short series of questions about safety and exposure to community and domestic violence. Finally, some practices fail to screen for domestic violence.

Both research and direct information from providers reveal obstacles to implementing a screening protocol for domestic violence (Sugg & Inui, 1992; Groves & Augustyn, 2001). Some of these barriers are common to all medical practice; others represent dilemmas that are unique to pediatric settings.

The first and most frequently mentioned barrier is that of time. There are demands on providers to see large numbers of patients, and at the same time there are increased expectations about what is to be covered in anticipatory guidance. The challenges of high volume, high acuity, and inadequate time may be especially difficult in primary care clinic settings committed to serving low income populations, particularly among Medicaid enrollees under capitated managed care arrangements (Szilagyi, 1998). Providers are always pressed for time and may avoid topics that lead to lengthy discussion or extensive demands for follow-up.

A second barrier is inadequate training. In a study of general violence prevention counseling, researchers found that 76% of pediatric residents and 83% of practitioners rated their training as inadequate in this area. In this same group, it was reported that 68% of residents and 73% of practitioners never or rarely screen for domestic violence (Borowsky & Ireland, 1999). In addition to being poorly trained, providers may lack knowledge about resources and local specialists in the area of domestic violence. They may be unaware of the local services for families affected by domestic violence, and they may not know how to find appropriate mental health resources for the child.

A third barrier is the provider's sense of powerlessness. Domestic violence is not a simple problem, nor do many patients want to talk about it. It is well known that women stay in relationships that are dangerous for them and their children because of economic constraints, lack of housing, or emotional reasons. Physicians are unlikely to be able to address any of these issues easily. For professionals whose success depends on efficiently diagnosing and effectively treating problems, domestic violence may represent a failure or a frustration that leaves the provider feeling helpless.

A fourth barrier is the concern that patients and their families will be offended if asked about domestic violence. Providers worry that patients will feel singled out by this line of questioning and resent it. However, a study done in 1999 showed that many women appreciated the questioning and revealed domestic violence when screened in the pediatric office setting (Siegel, Hill, & Henderson, 1999). Of the 154 women screened in this study, 31% disclosed domestic violence at some time in their lives, and 17% reported violence within the past two years.

A fifth barrier is that of language and cultural sensitivity. Providers may not speak the language of the patient; institutions may not provide adequate interpreter services. In addition, providers may lack sensitivity or knowledge about what it means within a particular culture to inquire about family issues or personal relationships. Thus, screening is less effective, and patient responses may be misunderstood.

Recommendations for Identifying and Assisting, in Pediatric Settings, Families Affected by Domestic Violence

All women in pediatric settings should be screened for domestic violence. There is considerable evidence to show that universal and regular screening of adult women by skilled health care providers, when conducted face-to-face in adult health settings, increases the identification of victims (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991; Koziol-McLain, Coates, & Lowenstein, 2001). There is reason to believe that universal screening in pediatric settings would provide similar opportunities for identification and intervention within families. When child witnesses of domestic violence and adult victims are identified early, providers are able to intervene to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions may lead to reduced morbidity and mortality (Saltzman, Salmi, Branche, & Bolen, 1997).

Screening provides women a valuable opportunity to tell their providers about their experiences with abuse. Battered women report that one of the most important parts of their interactions with their physicians was being listened to about the abuse (Hamberger, Ambuel, Marbella, & Donze, 1998). The pediatric or family practice provider's direct discussion about safety at home tells the patient that this is an important topic and one that belongs in the realm of pediatric and family practice care.

The question about screening men in pediatric settings for domestic violence (either as perpetrator or victim) is largely unexplored in the literature. In its deliberations about screening guidelines for pediatric and family health settings, the advisory committee to the Family Violence Prevention Fund's publication on this topic debated including men in its guidelines, but ultimately decided against it, citing several reasons for their decision (Groves, Augustyn, et al., 2002). First, the majority of child visits are conducted with women as the parent who accompanies the child. The majority of victims of domestic violence are women. Second, it is unlikely that perpetrators of partner violence would acknowledge their behavior in such a setting. Third, there was a concern by some that asking a perpetrator questions about domestic violence may have negative consequences for the victim and children.

However, we believe that every parent should be asked about safety in the home and community, and about their children's exposure to violence. We therefore recommend screening men who accompany their children to pediatric visits about safety in the home and community, and about their children's exposure to violence in the home or community. If a man discloses that he is abusive toward his partner, the provider should refer the man to a batterer intervention program, offer educational information, and arrange for follow-up visits.

Screening Questions

Screening for domestic violence should be conducted as part of routine pediatric health screening and within the context of questions about child safety and well-being that are a part

of anticipatory guidance provided by pediatric providers. For example, providers typically ask about car seat or seat belt use, or home safety. Embedding questions about personal safety in this context gives the message that concern about domestic violence is a logical and important topic to include, and that the provider has resources to suggest, if necessary. Screening may be done by a physician, nurse practitioner, or nurse assistant, depending on the specifics of that particular health practice. The guidelines from the Family Violence Prevention Fund recommend screening at all newborn baby visits, several times throughout the first year, and once a year afterward. Women should not be screened if their partners are in the room. Providers may ask 2-3 questions, beginning with a general statement, such as the following:

> *"I have begun to ask all of the women/parents in my practice about their family life as it affects their health and safety, and that of their children. May I ask you a few questions?"*

Introductory statements such as this one reassure parents that these questions are a routine and standard part of health care interventions. Providers may prefer to begin with indirect questions and then focus on direct questions.

Indirect questions may include the following:

- *"Do you feel safe in your home and community?"*
- *"How do you resolve conflict with your partner/husband/boyfriend or other adults in your home?"*

Direct questions would include the following:

- *"Have you ever been hurt or threatened by your partner/husband/boyfriend?"*
- *"Do you ever feel afraid of (controlled or isolated by) your partner/husband/boyfriend?"*
- *"Has your child witnessed a violent or frightening event in your neighborhood or home?"*

When a health provider asks about domestic violence in families with young children, it is generally preferable to ask the parent directly, rather than ask the child about his/her exposure to violence. Young children (usually those under the age of four) may lack the cognitive maturity to understand the substance of the questions. Therefore, they may answer the question incorrectly or unreliably. If children are living with domestic violence, they may be confused or afraid to disclose this information for fear of reprisal or out of loyalty to their parents. Direct inquiry of a young child may present an uncomfortable dilemma for the child: either tell a lie, or disclose the truth and be punished or suffer guilt at having disclosed a family secret. The provider has thus created more problems than he/she may solve by such questioning.

This is not the case for older children, who have greater psychological independence from their parents, and increased cognitive capacity to understand the question and respond accurately. Pediatric providers generally begin to ask older children directly about peer relationships, sexual activity, drug and alcohol use, and school safety in pre-teen pediatric visits. Questions about witnessing violent events in the home or community would be appropriate as well.

Asking Sensitive Questions with Children in the Examining Room

In most pediatric visits, the parent and child are together throughout the visit. Providers differ in their practice of addressing sensitive questions to the mother when the child is present (Zink, 2000). If the child is under the age of three, providers generally agree that asking these questions in the child's presence is acceptable. However, some providers are concerned about these queries when older children are in the room. They assert that the child's presence will be a barrier to parental disclosure. Some say that it would be upsetting for children to hear such conversation. Other providers believe that the screening questions about domestic violence should be asked regardless of the age of the child. They assert that children generally are aware of the domestic violence and that mothers will indicate if they are uncomfortable with the subject, thus giving the provider the opportunity to schedule a more private conversation with the parent. In their view, the discomfort of asking these questions in front of a child is out-weighed by the importance of communicating the practitioner's concern for the family's safety and well-being.

Recent guidelines suggest that screening should occur with the child in the room, regardless of his/her age (Groves, Augustyn, et al., 2002). If the parent is uncomfortable with the subject, or if the parent begins to describe situations that are obviously upsetting for the child, the provider can offer other options for talking more privately. In some cultures, it is particularly inappropriate to bring up family issues for discussion in front of children. For example, in many Asian cultures this inquiry may make parents quite uncomfortable, because family problems are not talked about with outsiders or in front of children. In some practices, the child can stay in a waiting area or under the supervision of another staff member. In other practices, this is impossible, and a follow-up telephone call or separate visit may be necessary.

If the parent and provider do not speak the same language, an interpreter should be used. Under no circumstances should a child be asked to translate these questions or facilitate this discussion.

Responding to Disclosures of Domestic Violence: The Pediatric Provider's Role

If the woman discloses that she has been a victim of abuse, the pediatrician's first duty is to assess the safety of the mother and her children. The provider should articulate concern about the woman's safety and ask questions to ascertain the current danger to the woman and child (see Appendix A). If the provider hears information that raises questions about safety, he should give the woman feedback such as the following:

> *"When I hear that your husband has made threats toward you, it makes me think that you and your children are in danger. What can we do to make this situation less dangerous for you? What do you need right now?"*

The provider should offer information about resources and options for help. These resources should be culturally and linguistically appropriate, and may include community resources as well as a local battered women's advocates' support group or shelter. In some settings there are social workers, domestic violence resource advocates, or child development specialists on staff who

could provide information, advocacy, and support to the parent. (See information below about model domestic violence programs in pediatric settings.) The provider should also offer to help the woman make a plan for safety and should schedule a follow-up appointment within a short period of time. If the mother does not wish to seek services, it is important that the provider recognize her right to make her own decisions about what is best for her and her children, and provide follow-up by scheduling a prompt return visit. The pediatrician should also assess the child's emotional adjustment (see box on Symptoms/Signs of Distress in Young Children, below) and safety.

The following might be the pediatric response to the visit by Juanito and his mother:

As the pediatrician is making notes in Juanito's chart, the mother says, *"Doctor, I saw you writing when we were talking. Does that mean you're going to report me to DSS? I know I sure don't need them in my life."*

"Oh, I'm glad you asked! I'm writing these notes so I don't forget the most important things we talk about and so that if there's a time I'm not here when you come in, the doctor caring for you will know what happened without your having to go through the whole story. I am not thinking about making a report because Juanito is safe, and you are taking good care of him. Is that okay?"

"Yes, it is, and thank you. Now I understand. But my main concern, Doc, is that I heard Juanito's father just got out of jail. I got called to the phone at work twice last week. But the person on the line was just breathing. He wouldn't say nothing. He just kept holding on, not saying a word. I thought it was him. And I started buggin' out, so I just hung up. You know, I got scared. Real scared. I almost fell apart right there. We were starting to do okay, me and my boys, and I just want to keep us safe. But we ain't got no phone. I think I need to find a lawyer. And I need to let my family know I'm okay, and to remind them that they shouldn't tell Juanito's father anything about where we live now. But I don't want people at work all up in my business. So could I use the phone here at the clinic?"

"Of course. That's a good idea. There's a lot we can do. We have a social worker who could help get that restraining order back in place. And maybe you should let Juanito's school know to be on the watch and not to give out your contact information. We'll put a special label on the medical record here so that it's not released to Juanito's father. Maybe there's even a way to get emergency phone services in place at your apartment."

"And what about Juanito's medicine?"

"Well, that may take some figuring out. We could talk to his teacher, and have a psychiatrist re-evaluate Juanito and see about the choice and dosing of his medicine. I wonder if we could also get a counselor for him at school. We can coordinate these things from here at the clinic."

"When do we come back?"

"You can come back anytime you think you need to. But, at the very least, I think we should plan to see Juanito here on a regular basis to follow things closely. Sorting out his troubles is complicated, but I'm confident we can do it if we work together. Let's make an appointment in a week just to check in about where things stand then."

"Thanks for your time, Doc."

"No, thank you. Helping you keep yourself safe is time well spent."

"Gracias, Doctor."

"De nada."

Role of Child Protection Services

If the parent discloses domestic violence, providers must inquire about risk or injury to the child. The provider may be required to make a report to child protective services (CPS) about the child's exposure to domestic violence. Each state has its own definition of child abuse and neglect, and there are widely divergent laws, policies, and guidelines that address the question of whether a child's exposure to domestic violence (without direct injury) is a form of child neglect. In some states, there are laws for mandated reporters requiring them to notify child protection services whenever a child is in the home and has been exposed to a parent's violence, whether or not the child has been directly abused. In most states, a child's exposure to domestic violence does not require a mandatory child protection report. There is wider discretion left to the provider to assess whether a child has been directly involved and what other factors may exist to put the child at serious risk. In these states, before deciding whether to notify CPS, a provider would take into account the existence of direct injury to a child, the potential danger of the situation, and the capacity of the mother and father to keep their children safe. Because the state's guidelines may be vague, providers may be unsure about what to do; they may avoid asking the questions, or they may make reports in situations that are unwarranted, thus unnecessarily subjecting the non-abusing parent and child to state intervention. In fact, battered women's advocacy groups in New York City have legally challenged the Children's Protective Services agency in that city over indiscriminate removal of children of battered women (Sengupta, 2000).

Pediatric providers must know their state's child abuse reporting laws, including specific policies on defining child exposure to domestic violence as child maltreatment. In a state that requires mandated reporting in all cases of domestic violence, the provider should inform the non-offending parent of the obligation to file a report to CPS, assess the safety needs of the adult victim, and inform CPS about the specifics of the perpetrator, his anticipated response, and the potential for serious harm. In states where exposure to domestic violence does not automatically require a mandatory child protection report, it is preferable to make the decision—about filing a report—based on the specifics of the case and the provider's clinical judgment about whether or not the child is at risk for injury or abuse, and how imminent this risk may be. If the situation is not currently dangerous, the provider can refer the victim to voluntary services: community-based

services, battered women's services, counseling (preferably with a provider who has worked with victims of domestic violence), or child-focused services. Reporting decisions are often difficult for the provider and may require consultation with colleagues or mental health clinicians who are knowledgeable about domestic violence.

If a report is filed, the provider should discuss this action with the parent to obtain information about the anticipated response of the perpetrator, the safety of the victim and children, and how and where to safely interview the parent. In some instances, the victim may prefer to be interviewed outside the home. The health provider should ensure that the protective services worker is aware of the potential safety issues and the victim's preferences for how the investigation might best proceed.

Documentation

Practice guidelines and recommendations about documenting the existence of domestic violence in the child's chart are contradictory and inconsistent. One recommendation is for the provider to document in the child's chart that a screening for domestic violence was conducted (King & Strauss, 2000). This type of routine documentation is recommended for tracking and quality assurance purposes. If possible, the documentation (if positive for abuse) should be placed in the woman's health chart or in social work notes where there is more protection of confidentiality. Some practices use non-specific terms or a code word to indicate the presence of domestic violence in a child's chart: for example, "family problems," "difficult home situation." Other practices maintain a section of the child's chart that is confidential and is not released when there is a request for medical records. A brief notation of domestic violence in this section is appropriate.

The dilemmas about documentation raise the basic question about who the patient is. In pediatric settings, the patient is the child. A parent can read anything written in the child's chart. If the batterer is the biological or custodial parent, he may have access to the chart. Therefore, putting information about domestic violence disclosures in the child's chart may be endangering or inadvisable. On the other hand, the information is important because other providers working with the family should know about this risk factor.

Model Domestic Violence Programs in Pediatric Settings

The AWAKE (Advocacy for Women and Kids in Emergencies) Program at Children's Hospital, Boston

AWAKE is an innovative program that provides advocacy to battered women in conjunction with pediatric services for children. In the mid-1980's, staff at Children's Hospital realized that interventions which focused exclusively on abused or neglected children missed the larger context of violence within the home. Knowing that they could better protect children by helping their mothers, staff designed a hospital-based outreach and intervention model to assist battered women. Services include individual counseling, risk assessment and safety planning, assistance

in securing emergency shelter and legal representation, and a walk-in support group. AWAKE works regularly with health care professionals and social workers in the hospital and in its affiliated neighborhood health centers, both on individual cases and on training and policy development.

The Community Advocacy Program (CAP)/ Center for Community Health Education, Research, and Services

The CAP program, a collaboration of six community health centers located in Boston, expands health and social services for domestic violence victims. A family advocate at each health center provides adult victims with case management services, support groups, and referrals for services. The advocate is generally from the community, reflecting the culture and language of the population that uses the health center. The family advocate works closely with adult and pediatric health providers to ensure that screening occurs and to provide on-site direct counseling services, linkage with legal or housing assistance, and victim compensation services. This program is based on the premise that community-based health services for women and their children are the ideal setting for identification of families experiencing domestic violence and for long-term intervention. This model of locating an advocate directly within a community health practice is praised by health providers; it increases their comfort with screening for domestic violence because they have immediate access to resources such as advocates who offer help to families.

Healthy Steps for Young Children

Healthy Steps is a national pediatric initiative which seeks to transform primary care for young children by infusing child development information and family support into pediatric well child visits. The approach involves the addition of a new member to the healthcare team—a Healthy Steps Specialist who brings training in child development and mental health to enhance information and services to families. Healthy Steps Specialists work alongside the primary care clinician to enhance well child care by providing information on behavioral and developmental issues for the baby and by addressing those adult risk factors which impact child behavior and development, such as parental depression and domestic violence. Healthy Steps practices ask families about their relationships and provide referral services for those who report concerns about their safety and the safety of their children. Healthy Steps Specialists provide home visits, conduct developmental "check-ups" for the child and the family, facilitate appropriate referrals, and staff a child development telephone information line. Healthy Steps is unique among early childhood interventions in that it is based in a healthcare setting, offers a "universal" approach to addressing the needs of all families, and introduces a new professional into the health care system. More information can be obtained at their website: http://www.healthysteps.org

Responding to Child Witnesses to Domestic Violence

The six-year-old boy, Juanito, mentioned in the earlier case study, provides a dramatic example of how children may be psychologically affected by domestic violence and its aftermath of homelessness, frequent moves, and poverty. This case also raises the importance of early

identification and intervention; if Juanito's needs had been recognized at age two and he had received appropriate intervention—including counseling, parent guidance, and high-quality day care—he might have avoided some of the risks he now carries.

If a pediatric provider determines that a child has witnessed domestic violence, the practitioner should assess the child's emotional status and functioning. Children react in different ways to trauma, and they have a range of strengths and vulnerabilities which affect their coping with this stress. Some children appear to be resilient; others may be deeply affected. In addition, there are responses from the caregiving environment that are more or less supportive of the child.

Symptoms/Signs of Distress in Young Children *

- Sleep difficulties, nightmares, fear of falling asleep
- Separation anxiety, persistent worries about a parent
- Vague or diffuse somatic complaints
- Increased aggressive behavior or angry feelings
- Loss of previously acquired developmental skills
- Distractibility, difficulties with concentration
- Repetitive play or talk about upsetting events

*These symptoms may be associated with many stressors in early childhood. Exposure to violence should be considered as a possible cause.

A child who has witnessed domestic violence should not automatically be referred to counseling. The pediatric provider should inquire about the child's reactions and symptoms and listen carefully to the parent's concerns. There are several options for support and assistance, depending on the resources in the community, the comfort and ability of the parent to access services, and the severity of the child's distress. Referrals should be made to services with cultural sensitivity and language appropriate to the family. There is a continuum of supports for young children's social and emotional development that effectively addresses stressors such as exposure to domestic violence. In some communities, early child care services provide mental health consultation and support to parents as part of child care. There are also parent support groups, family resource centers, or community agencies that can offer support to young children and parents. If the abuser is still in the home, it would be important to address basic safety issues before making a referral. The mother may worry that the father would not support a referral for the child.

In some instances, the level of distress of the child, or the concern of the parent, may warrant a referral to a mental health professional. In one report of symptomatology of children age six and under who had been exposed to domestic violence, the symptoms most frequently mentioned by parents were aggression, oppositional behavior, and sleep disturbances (Groves, Acker, et al., 2002). These symptoms can be intense and should be regarded as a clear indicator of distress.

Health providers might discuss such a referral with a parent in the following circumstances:

- If the parent is concerned about the child's behaviors or symptoms.
- If the child witnessed severe violence, resulting in injury or hospitalization of either the child or the parent.
- If the child's symptoms have persisted for more than three months. (See box on the Symptoms/Signs of Distress in Young Children.)
- If the violence resulted in the death of a parent.
- If the caretaker is unable to be emotionally attuned to the child's needs.

In these circumstances, and if it is safe to do so, a referral should be made for counseling. The goal of counseling is to help the child manage his/her intense emotional reactions to the trauma, to assist the parent with accessing safety and other concrete supports, and to assist the child and parent to develop strategies to reduce symptoms so that the child is better able to function at home and in childcare settings.

The health provider should be sensitive to the parent's receptiveness to such a referral. In some instances, a parent may worry about the stigma of seeking mental health services, or she may experience guilt or shame that she has not been able to protect her child from the effects of domestic violence. In many cultures, mental health intervention carries a particular stigma; it is not acceptable to talk with "outsiders" about family problems; it is not accepted that young children may suffer from trauma. The provider should acknowledge the parent's ambivalence about seeking help, and reassure her that seeking assistance is important for her child. It is also essential to be able to make referrals to mental health clinicians who understand and, if possible, offer services from multicultural and multilingual perspectives.

Referrals to Mental Health Services

It is best to refer the child to a mental health clinician who has experience working with families affected by domestic violence and who is knowledgeable about young children and trauma. However, the referring pediatrician may encounter a lack of appropriate mental health resources for children, particularly young ones. In part, this shortage reflects a denial of the reality that young children can suffer from psychological distress that is similar to that experienced by adults. There is a widespread belief that their age protects young children against trauma and that young children will "grow out of their problems." Another myth is that it is unhelpful for young children to talk about their problems, because they will probably forget them. The case of Juanito serves as grim testimony to the enduring power of trauma in a young child's life.

Unfortunately, there are relatively few mental health professionals who are experienced in working with families affected by domestic violence and trained to work with pre-school children. Graduate schools of psychology and social work generally do not offer specializations in early childhood. A well-meaning and knowledgeable therapist who does not know about the dynamics

of domestic violence can inadvertently make the situation more dangerous for the child and the non-abusing parent. (See "Recommendations for Practice in Mental Health Settings," below, for suggestions about how to strengthen mental health services for families affected by domestic violence.)

The constraints of the managed health care system offer a final obstacle to finding adequate mental health services for young children. Managed care health insurers may limit the number of sessions a family can have, and they dictate the nature of the sessions in ways that overlook the needs of young children. For example, mental health consultation to a day care center may be an essential component of intervention for a young, traumatized child, in order to help him stabilize. However, insurance will not pay for a therapist to visit the day care center.

Recommendations for Practice in Mental Health Settings

The following recommendations would improve mental health services for young children affected by domestic violence.

1. *Train child mental health clinicians to use a model of mental health assessment and treatment that combines a thorough knowledge of early childhood development, trauma, and the effects of domestic violence on all family members.*
2. *Implement the recommendations in the U.S. Surgeon General's report of 2001, to ensure that mental health providers acquire cultural competence and sensitivity in understanding child development, family relationships, and the meaning of seeking mental health services across cultures (U.S. Public Health Service, 2001).*
3. *Increase the number of providers who can offer mental health services to children by training a broad range of professionals to recognize and intervene with children exposed to domestic violence, including family support workers, outreach workers, and advocates.*
4. *Offer a range of services to children and non-abusing parents, recognizing that children are affected differently by exposure to violence. Services might include individual assessment and treatment, groups for children and for mothers, and educational material made available to the families.*
5. *Offer referrals for batterer intervention programs for abusers; when it is appropriate and safe, involve abusing parents in parent guidance or parent education about the impact of domestic violence on children.*
6. *Incorporate an ecological/advocacy perspective into clinical mental health treatment, working collaboratively with domestic violence advocates; community-based, culturally-specific services; the courts; and other agencies on behalf of children and families. Many low-income families experiencing domestic abuse require help with meeting their basic needs for housing, income, and food. Many abused women will find it difficult to protect their children without these basic supports.*

7. *Because of the overlap between child maltreatment and domestic violence, develop policies that are within the state's guidelines for reporting suspected abuse or neglect and that also take into consideration the special circumstances of domestic violence within families. Develop protocols for making reports that ensure the safety of family members and avoid blaming the victim for acts that were beyond her control.*

The Child Witness to Violence Project at Boston Medical Center: A Mental Health Program for Young Children Who Witness Domestic Violence

The Child Witness to Violence Project is located in the Department of Pediatrics at Boston Medical Center and provides outpatient counseling services to children age eight and under (and their families) who have witnessed significant violence. Through state and federal funding, services are offered at no cost to the families. Approximately 80% of referrals are for children who have witnessed domestic violence. Families are referred to the project from a wide range of sources: courts, domestic violence shelters, health centers, early childhood programs, and schools. Approximately 25% of referrals come from victims of domestic violence who are concerned about their children. The staff of the project are mental health clinicians with training in early childhood development, trauma, and domestic violence.

Children are usually evaluated with the non-offending parent and are seen in individual treatment. Parents are closely involved in the treatment; sometimes they are seen directly with the child, or they meet separately with the child's therapist. The general goal of intervention is to restore equilibrium for the child and family, to allow the child a safe place to talk about what has happened, to help the child gain a better perspective on the traumatic event, to help the parent better understand the child's behavior, and to equip her with strategies to help the child. The Project uses an ecological model of intervention, working actively with the child and family's network of caregivers: schools, child care centers, health providers, the courts, and child protective services.

The Child Witness to Violence Project has published a curriculum to train child mental health clinicians. The curriculum includes information about providing intervention that is sensitive to issues of race, class, and culture. In addition, staff have trained pediatric providers, court personnel, police, and child protective services staff throughout the country.

Policy Recommendations from a Pediatric Perspective

This paper has focused on the role of pediatric and mental health clinics in identifying and supporting young children and families affected by domestic violence. The following recommendations would strengthen the capacity of these systems to respond more effectively to families:

1. *The American Academy of Pediatrics and other professional medical associations should support and promote guidelines for universal screening for domestic violence in pediatric*

settings. Endorsements from professional associations are essential in setting policy and practice guidelines in health settings.

2. *Graduate programs for mental health clinicians should offer courses on working with adults and children affected by domestic violence. This training should include information about the developmental impact of trauma on children and how to provide clinical services in a culturally sensitive manner to children and families.*

3. *Early childhood professional associations, government agencies, and medical professional associations should promote and publicize the importance of early identification and intervention with young children who witness domestic violence. This increased recognition would justify better funding for mental health services. Important work has been done in this area by the National Academy of Sciences in its book* From Neurons to Neighborhoods, *which provides a comprehensive overview of early child development and the role of genetics and environmental influences on early child development (National Research Council and Institute of Medicine, 2000). If children are identified early in life, services can be put into place that assist them before they suffer chronic or more acute emotional difficulties. Health settings are uniquely situated to provide this early identification.*

4. *Stronger and more comprehensive collaborations should be promoted between pediatric providers, legal advocates, community-based providers, culturally-specific services, and women's health professionals. Such collaborations would ensure that pediatric providers could respond more effectively to women's unattended needs by linking patients to help with housing, economic supports, restraining orders, safety planning, and legal assistance.*

5. *More funding should be allocated for mental health services for young children and families affected by domestic violence. As health care screening for domestic violence improves, we should anticipate an increase in need for services. One example in this area is the new federally-funded network of services for children who are traumatized, the National Child Traumatic Stress Network, funded by the Substance Abuse and Mental Health Services Administration, DHHS. This grant supports the development of models of treatment for a wide range of traumatized children, including young children who are affected by family violence.*

6. *Medical and other professional settings should provide better training of pediatric and mental health clinicians to screen, assess, and intervene with young children and families affected by domestic violence. Health providers need specific training about how to screen, what to look for, and how to help families access resources. Mental health professionals need training on clinical intervention in families affected by domestic violence, with an emphasis on the specific dynamics of these families and ways to shape interventions that take into account the safety risks of family members. Both health and mental health providers need training in screening and intervening in a culturally sensitive manner.*

7. ***Government and private funding agencies should place more emphasis on prevention, particularly working with young fathers. This includes the recognition that gender inequality underlies violence against women; that the stressors of poverty, unemployment, and racism are breeding grounds for violent behavior; and that a comprehensive approach to domestic violence prevention must take into account these larger issues of social inequality and poverty.***

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Appendix A

Assessment of Danger in Domestic Violence Situations

Questions to Ask

- What kinds of threats has your partner made to you? To your children?
- Has your partner threatened to kill you or your children?
- Does your partner have access to weapons?
- Have you ever needed to seek medical treatment after a fight with your partner?
- What was the most serious injury he/she caused?
- Has the abuse gotten worse in recent months/weeks?
- Does your partner try to control or monitor your daily activities?
- Does your partner have a history of mental illness?
- Does your partner drink or use drugs?
- Have you tried to leave in the past? What happened?
- How dangerous do you think the situation is right now? What are you most worried about?


Early Childhood
Domestic Violence
Poverty

Young Children Living with Domestic Violence: The Role of Early Childhood Programs

Series Paper #2

Introduction

Children exposed to domestic violence are in our early childhood programs and schools as well as in pediatricians' offices, public health clinics, and child welfare agencies and systems. Although domestic violence cuts across all social and economic groups, low-income families are more likely to be affected. A large proportion of poor families are families of color who also struggle with the negative cumulative effects of racism and other pervasive problems, such as living in unsafe neighborhoods and lack of housing and high-quality childcare.

During the last decade, awareness of the potential harm to children exposed to domestic violence has grown. Studies of children exposed to war and other catastrophic stressors indicate that such events can threaten their emotional, physical, and social development. Children affected by domestic violence develop a range of specific service needs related to their safety and their mental, physical, and cognitive development. Research also indicates a significant overlap between domestic violence and child abuse—in families where one form of violence exists, it is likely that the other does, too (National Council of Juvenile and Family Court Judges, 1999).

Important protection for children who experience violence and other risk factors comes from access to high-quality early care, to education programs with stable caregivers, and from the opportunity to experience a nurturing, stimulating environment. For families, many of these programs can also provide information, connection to other resources, and sometimes direct services, such as legal help, housing assistance, and access to batterer intervention programs.

This paper provides practical information and resources for staff working directly with young children and their families in early childhood programs and domestic violence agencies. It also highlights the role that program administrators and the early childhood community can play in supporting staff and strengthening community and state partnerships and policies on behalf of young children and families affected by domestic violence.

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The Early Childhood Education "System"

Early childhood programs tend to be described as a unified system, but they are, in fact, an array of various programs that differ widely in their funding, goals, service delivery strategies, and the ages of the children that they serve. The most common type of child development settings that target children from birth to age six include childcare (centers and family daycare homes), Early Head Start and Head Start, Even Start, educational home visiting, early intervention, and pre-Kindergarten and Kindergarten (see box: Early Childhood Education Programs). Moreover, childcare is not a single intervention in children's lives. Rather, children—especially infants—move in and out of different childcare arrangements and often experience multiple arrangements simultaneously over the course of their early childhood years. For example, low-income families typically rely on combinations of childcare (e.g., attending part-day Head Start and then using childcare for the rest of the day, or combining relative and family childcare).

Early childhood programs serve many functions. They make it possible for parents to work; provide young children with nurturing, developmentally appropriate early learning experiences; help parents understand what young children are like; and often serve as an early warning system to identify young children who need additional supports. They also play a critical role in providing a stable, non-stigmatizing environment for children at risk for physical, cognitive, and social delays as a result of their home environment or other environmental stressors.

Although the specific goals, staff characteristics, and quality of childcare vary, most programs are based on the principles of providing early care and learning experiences in the context of developmentally, culturally, and linguistically appropriate services. These values are embedded in the requirements and/or guidelines of the National Association for the Education of Young Children Accreditation, Head Start Performance Standards, and State Childcare licensing rules. Some programs, particularly Head Start and Early Head Start, also include staff members who work primarily with parents, providing support, connecting them with resources, and helping them become better parents.

Addressing Issues Related to Domestic Violence

Both research and common sense suggest that early childhood providers can play important roles in helping to prevent or reverse early harm to young children from exposure to domestic violence. From a research perspective, a compelling, cumulative body of research indicates that young children who participate in high quality early childhood experiences show gains in all aspects of development and in school readiness (Gomby, Behrman, Lewis, & Stevenson, 1998). Research on interventions for young children experiencing risk factors, such as domestic violence coupled with poverty, highlights the importance of intentional efforts to promote healthy social and emotional development, to strengthen (or repair) damaged relationships with primary caregivers, and to ensure that there are other caring and stable adults in the child's world (Knitzer, 2000).

Early Childhood Education Programs

Childcare. Childcare programs typically offer group care all day, either in a center or in a caregiver's home, to children from birth to school age. Most of these programs seek to promote healthy child development as well as free parents from their childcare responsibilities so they can work. Many children, especially infants and toddlers, are also in "kith and kin" childcare (i.e., care provided by neighbors and relatives).

Early Head Start. A federal program, Early Head Start serves low-income pregnant women and children under age three in poor families by promoting child development and enhancing family efforts to nurture and educate their children.

Head Start. A federal program for low-income families, Head Start serves children from age three to five by adopting a two-generation strategy that reaches both children and their parents through individualized child development and family support services. Head Start endeavors to promote social competence and ensure that children succeed in school.

Even Start. Serving low-income families with children from birth to age eight, this federal family literacy program combines early childhood and parenting education with adult literacy or adult basic education. In FY 2002, under the Reading First Initiative, states acquired the option to receive funding from a new Early Reading First program to implement research-based pre-reading methods in preschool programs with some of the Even Start goals.

Educational Home Visiting. A number of early childhood programs employ a home visiting strategy with diverse goals, such as promoting healthy child development or school readiness, preventing child abuse, providing parents with information about child development, and enhancing parent-child relationships. These programs share a focus on the importance of children's early years and the sense that one of the best ways to reach families with young children is by bringing services to them rather than expecting them to seek assistance in their communities. Funding for educational home visiting comes from sources as varied as the federal Office of Juvenile Justice and Delinquency Prevention, Head Start and Early Head Start, the Maternal and Child Health Bureau, Title I, state Children's Trust funds, and foundations.

Early Intervention. This federal program is designed to ensure that young children with disabilities, regardless of income, receive a multidisciplinary assessment of their disabilities and referrals to needed occupational, physical, communication, or other therapies. Early intervention requires a "family service plan" that assists parents and other caregivers in learning to deal with the problems the child faces. Preschool Special Education Grants provide an entitlement to special education and related services for children with disabilities from age three to five.

Pre-Kindergarten and Kindergarten. Typically, pre-Kindergarten and Kindergarten are part-day and part-year programs, funded by states and communities, that bring together four- and five-year-olds in centers or school settings. They aim primarily to promote child development and improve children's readiness to succeed in school. Publicly funded preschool programs usually serve children from disadvantaged families, while private preschool programs supported by parent fees serve children from all backgrounds. Efforts are now underway to provide universal access to pre-Kindergarten.

For children exposed to domestic violence and other stressors, both formal early childhood programs (e.g., daycare centers, Head Start, nursery schools, and pre-Kindergarten) as well as care by family daycare providers, neighbors, and relatives, can offer a kind of "safe haven." Through nurturing and caring relationships, which evolve in the course of their daily contacts and through curriculum activities and routines, children can develop new social, emotional, and language skills. Further, staff are in an ideal position to identify when a child might be having difficulties, or, for some, to cushion the child's experience of trauma and promote effective coping that might reduce the need for placement or for more formal mental health interventions or later difficulties.

Early childhood programs (especially Early Head Start and Head Start) that take a holistic approach to serving families and address education, employment, and lack of basic resources, are also in a strong position to help families. Sometimes, because parents trust them, they may be the first to learn about domestic violence—either through children or parents' disclosure. They can help parents understand how to help their children deal with the violence, and support the parents as the nurturers and teachers of their children.

Some have expressed concern that adding a focus on domestic violence to already-burdened early childhood staff, who earn too little money and have too few supports, is not realistic. But staff are already dealing with these children and families. Helping them to do so intentionally and with new competencies can only improve their abilities and job satisfaction, and the quality of the overall program.

Supporting the Needs of Young Children Who Live with Domestic Violence

Young children who witness violence are a heterogeneous group, and responding to their needs requires a range of flexible strategies. Some children need nothing more than a high-quality early childhood setting, either with a family childcare provider, or a center-based program. Others, however, may show warning signs that they are experiencing more distress, and staff need to know how to identify these children and, if necessary, make appropriate referrals for early intervention or mental health supports. Many of the strategies that can help young children exposed to domestic violence are the fundamentals for quality early care and learning programs—for example, a predictable environment with a variety of opportunities to express feelings in verbal and nonverbal ways. Other strategies must be tailored to the particular circumstances of a child and family living with domestic violence.

New Strategies in Early Childhood Programs

In view of the important role that early childhood teachers, family childcare providers, home visitors, and family support workers can play in ameliorating the impact of domestic violence for young children, as well as the large numbers of young children who experience this risk, early childhood programs over the last decade have begun to implement various strategies, as follows:

- *Increase the capacity of all staff to address domestic violence.* Strategies include increasing staff's awareness about domestic violence, training staff to respond to child disclosures, and encouraging staff to identify and support the needs of women living with domestic violence. In the larger early childhood programs, employee assistance programs have supported staff members who live with domestic violence.
- *Educate all parents (including fathers) about the impact on children of exposure to community and domestic violence, and how to help children cope.* In the course of parenting education, Early Head Start and Head Start programs are beginning to pay special attention in their work with all parents to addressing issues related to violence. In addition, programs are reaching out, through male involvement projects, to fathers and other significant men in the lives of the children they serve. Staff provide information to all participating men on the impact of domestic violence on children. They may also participate in assessments of issues such as whether a father or other male in the home poses a physical or psychological risk to a child, the nature of the father's attachment to the children, or assessment of age-appropriate discipline and limit setting.
- *Develop procedures to respond to the special needs of children and families experiencing domestic violence.* Some Head Start programs save a number of slots to serve children in domestic violence shelters or entering the foster care system. Other programs are working with mental health consultants to help staff understand how and when to refer young children to witness-to-violence programs, therapy, and early intervention programs for developmental issues.
- *Become part of a more coordinated response to children and families living with domestic violence.* In some instances, domestic violence and childcare agencies have co-located specialized staff to assist victims of domestic violence (in early childhood programs) or children (in domestic violence programs). Head Start programs also have included domestic violence staff on their Health Services Advisory Committees.

Strategies for Childcare Staff

In spite of these innovative strategies, most early childhood program workers know little about how to offer help to families or to children living with domestic violence. Often, staff members are unclear about their role and afraid they might be prying into private family matters. Cultural differences sometimes increase staff discomfort, discouraging them from exploring sensitive issues. The adult women bringing their children to the center might appear to be strong, and as if they would be easily insulted by an inquiry about their safety. Staff members also feel anxious about their personal safety and inadequate with regard to their intervention skills. Some workers involved with the families are themselves current or former victims of abuse and might be especially reluctant to open these issues.

Similarly, the programs might be unequipped to handle the complex issues surrounding domestic violence. Inadequate policies, weak community partnerships, and lack of legal knowledge can

hinder program efforts to protect children and families in abusive situations. All staff—those who work directly with the children and families, and those who are administrators and supervisors—have a role in helping early childhood programs to better meet the needs of young children and families coping with domestic violence.

Strategies for Staff Who Work Directly With Children

Teachers, home visitors, and other non-familial caregivers within early childhood programs can play a key role in helping children within the classroom and family childcare homes, as well as during home-based visits, by using the following strategies:

- *Create a safe, nurturing environment.* Young children need to be and feel safe, and they feel safe when they know they are loved, respected, and protected. Nurturing environments are created through positive relationships; a curriculum with culturally, linguistically, and age-appropriate experiences that promote learning and self-esteem; predictable routines; clear expectations; and many opportunities for learning to solve problems without aggression and to play in nonviolent ways.
- *Respond to each child's needs.* Just as the intensity and severity of domestic violence varies, so do children's responses. Some children are resilient and show few signs of distress, others experience much more complex and harmful consequences. Staff working directly with young children are in a particularly good position to encourage (without pressuring) a child to talk about the traumatic event in the safety of a relationship; observe warning signs that a child is experiencing difficulties; help a child understand that parents' fighting is not his or her fault, and that he or she is not responsible for managing it; and facilitate positive bonds between a child and the nonviolent caregiver.
- *Build skills for dealing with challenging behavior in young children.* Children who have been traumatized by violence might react by behaving in ways that show their stress and fear. These behaviors might be similar to those demonstrated by children who are dealing with other challenges (see box: Dealing with Difficult Behaviors).
- *Be prepared to deal with complex—including legal—situations.* Become aware of program and state protocols for filing a report or for calling the police in crises. Be prepared to carry out custody orders; to address suspicions and evidence of concurrent abuse of the children by one or both parents (see box: Public Child Welfare Agencies and Early Childhood Programs); to make referrals to domestic violence agencies, or, if necessary, to Child Protective Services; and to be aware of and ready to implement safety plans.
- *Refer children whose problems are clinically significant.* Some children who live with domestic violence might need referral to programs such as child or parent-child therapy, therapeutic childcare, play groups, or child-witness-to-violence programs. These children should be referred to mental health providers who understand trauma, domestic violence, and the developmental needs of low-income, minority children. The caregiver needs information

Dealing with Difficult Behaviors

Regression. Children under stress tend to forget some of the things they have learned and regress to earlier behaviors, such as bedwetting, toilet accidents, and thumb-sucking. Adults can relate to children at the age level they have returned to and try gently to help them regain these skills.

Separation anxiety. Children traumatized by violence might experience difficulty separating from their parents or other early care and education providers and become clingy. Adults should be patient and give children extra time during transition periods in the day—such as being dropped off at childcare or picked up from school, or at bedtime.

Fear. After a traumatic event, fear might be one of the child's strongest emotions. Let children know that it is okay to be scared; they do not have to be brave. Let them know they are not alone and that you are there to protect and love them.

Breaking the rules. Try to maintain the same rules and expectations. Knowing what is expected from them helps children feel safe. Avoid physical punishment, which only shows that it is okay to use violence to solve problems. Learn other methods, through parenting classes or other help, to deal with this behavior.

Anniversary reactions. Children's reactions to violent events can occur after much time has passed. They might begin to show signs of stress around the anniversary of the date when the violent event happened. Anniversaries provide an opportunity to acknowledge the feelings that are still there and also talk about new feelings and thoughts.

Nightmares. Nightmares are common in children who are under stress. Encourage parents to create conditions that promote sound, peaceful sleep, such as establishing nap and bedtime routines, reading a special book, and withholding caffeine and sugar from children before they go to sleep.

Source: Cohen, E., & Walthall, B. (2003). *Silent Realities: Supporting Young Children and Their Families Who ExperienceViolence.* Washington, DC: National Child Welfare Resource Center for Family-Centered Practice.

on how to follow up these interventions in the classroom and how to help the family follow up at home.

- *Know how to respond to disclosures from children.* Children might demonstrate in their play or directly disclose being exposed to domestic violence in their home. It is especially important that teachers, family childcare providers, and home visitors be prepared to respond to these disclosures so that the child feels heard, supported, and safe. Teachers must remain nonjudgmental, calm, and neutral in responding, and must remember that their role is to support the child rather than to gather evidence or investigate the situation (see box: Responding to Disclosures from Children).

- *Consult a supervisor, a mental health worker, or both, when concerns arise.* Caregivers who have no access to these experts should consult their local childcare and referral or domestic violence agency.

Strategies for Staff Supporting Families

Effective interventions for young children exposed to violence (or experiencing other traumas or challenges) must incorporate support for their families. Families who live with domestic violence sometimes dwell in environments where poverty, substance abuse, depression, homelessness, and other stresses have taken a toll, leaving them with little energy or skills to nurture and stimulate their children.

For those working in low-income communities of color, it is important to understand how racism and social oppression may impact family relations. Legal and criminal responses to minority families—for example, to those reporting domestic violence—may be different from responses

Public Child Welfare Agencies and Early Childhood Programs

Many children who witness domestic violence are also at risk of child abuse or neglect. All states currently have child welfare systems that receive and investigate reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home. Some states have implemented (or are considering) legislation to broaden the definitions of child maltreatment to include children exposed to domestic violence. Public child welfare agencies are building partnerships with, and helping direct resources to, community agencies serving families affected by domestic violence—including early childhood programs.

Domestic violence does not equal child abuse or neglect, and therefore not all cases of domestic violence must be reported to Child Protective Services. In most states, reporting should be the "last stop" as an intervention. The primary focus of the early childhood caregiver should be safety and stability for the child, which is often achieved by helping the non-offending parent and working with service providers and law enforcement to help, and hold accountable, the offending parent. Assessing risk to the child and evaluating the dangerousness of the offender, the impact of the violence on the child, and the non-offending parent's help-seeking ability, are critical.

Unfortunately, the early childhood caregiver will sometimes have inadequate time to refer, consult, or assess risk adequately. In these situations, the caregiver should err on the side of caution and call a supervisor or local child protection agency for consultation. If a report to the child welfare agency must be made, he/she should gather as much information as possible and be prepared to tell the child protection agency about the risk to the child, the dangerousness of the offender, and the mother's help-seeking abilities. The caregiver should talk to the mother before filing, unless doing so will compromise the child's safety. It is important to remember that a person's, family's, or social group's experiences with the world-at-large and in the community often affect their interactions with legal resources and law enforcement.

Responding to Disclosures from Children

Programs have different policies; teachers and other staff have varying comfort levels in talking with children or parents about these issues. If a staff member suspects domestic violence, he or she should always talk to other program staff, and/or call for additional resources, to assist in deciding what to do and how to do it. Some general suggestions include the following.

If a child discloses information about domestic violence in the home:

- Consider the child's disclosure within the context of what you know about the child and family.
- If appropriate, take the child aside and ask a few follow-up questions about what happened and about general safety. Possible questions include: "What happened?" "When Mommy and Daddy were fighting, where were you?" "Was anyone hurt?" "Were you worried or scared?" Follow the child's lead.
- Reassure the child by acknowledging his or her feelings, saying, for example, "it sounds like that was very scary for you."
- Let the child know what will happen next and reaffirm your support.
- Do not criticize or speak negatively about the abusive parent.
- When possible, consult with a supervisor, family services worker, or director about next steps. When they are unavailable, consult with a domestic violence program or another source of support.
- Document the disclosure.

Follow-Up:

- Ask the mother if she is concerned about the safety of any member of her family. Ask if she is safe in the home. Depending on her response, reassure her that children sometimes share things in a school setting that worry them and that you know this can be difficult or embarrassing for the parents. Your role is to offer support and access to services, rather than judge, when families are in need.
- Share your concerns from the perspective of the child's adjustment in the childcare program.
- If there is a report of direct injury or possible risk of injury to the child, you might be required to file a report with Child Protective Services. Know well your internal policies and procedures regarding making the report. If you need to contact Child Protective Services, explain to the parent that you have no choice—you are mandated to call.
- Schedule a private meeting with the mother to discuss the child's disclosure. A staff member whom the mother knows and trusts should conduct this meeting. Tell her what the child has said.

to non-minority families. This may have an impact on the way families get referred, accept treatment, and respond to interventions.

Some early childhood programs have access to staff and resources—such as family support workers, social workers, and early childhood mental health consultants—who can play important roles, in accordance with their job description and expertise, in facilitating an informed and supportive response to families. The challenge is greater for those working in family settings (either licensed family child care or informal care arrangements). Establishing linkages with domestic violence shelters, with family support programs, and especially with childcare resource and referral agencies can be helpful.

No matter how much experience someone has, bringing up the topic of domestic violence is always difficult. Women who are victims of domestic violence might feel guilty for failing to protect their children or for remaining in the abusive situation. They might see themselves as incompetent parents. Often abusers justify their actions by criticizing their victims. However, the conversation with early childhood or family support staff might be the "gateway" to begin the healing for the whole family.

In addition to the usual strategies for assisting parents in the context of early childhood programs, family service workers and other staff can play a key helping role.

- *Be respectful.* Acknowledge the uniqueness and complexity of each family and convey that you respect their cultural, racial, and linguistic background. Always take seriously family members' concerns about their safety. Listen to them when they talk about things that have helped and might protect them. Try to talk to—not "interview"—the mother alone. Begin with non-threatening, general, open-ended comments and questions. For example, "All families argue; in fact, disagreements can be healthy as long as people don't feel threatened or intimidated. Tell me about your relationship with your husband/boyfriend." (See box: What *Not* To Say When Talking about Domestic Violence.)
- *Talk to mothers about their child's disclosures.* If a mother denies or minimizes the domestic violence, but the child has made allusions to or described it, consider sharing the child's descriptions with her. Assure her that you are concerned about the child's safety and well-being as well as her own safety. Reassure her that you will refrain from confronting the batterer with the information she reveals. Use your judgment: if you think sharing the child's descriptions could put the child at risk, do not mention them in your discussions with the mother. Help the mother understand—without making her feel guilty—how violence might be affecting her child. Make it clear you understand the domestic violence is not her fault.
- *Ensure that the mother has a safety plan.* For families facing domestic violence, having a safety plan in place is critical. Family support workers can either help families develop such a plan or connect them with those who can, drawing on their knowledge of the

domestic violence agencies in the community. (See box: Domestic Violence Programs and Services.) More specifically, family workers can ask the mother for permission to talk about the situation with her extended family and with domestic violence agencies and, before a domestic crisis occurs, help the mother make a plan that describes ways to keep her and her children out of immediate danger. Emphasize that what to do about the abuse is her decision but that you want to help her ensure the safety and well-being of the children. If the mother is in a dangerous situation, provide support information and assistance.

- *Help parents talk to their children about the violence.* Finding violent events inexplicable and horrifying, most adults are unsure how to explain violence, serious injury, and death to young children. Help parents and other family members respond to children's worries truthfully and with whatever reassurance is possible. Children need to understand that what happened is not their fault and they need to be helped to feel safe as well as to be safe.

What *Not* To Say When Talking about Domestic Violence

When talking about domestic violence, the right words are especially important. Inappropriate verbal interactions—even when they are not intended to be hurtful—can feel like further victimization. Examples of inappropriate questions include the following:

- "Are you sure this happened?" (disbelief)
- "What did you do to set him off?" (blame)
- "Isn't this accepted in your culture?" (cultural insensitivity)
- "How can you stay?" (judgment)
- "The pain will go away. Things will get better." (minimizing)

Source: Ganley, A., & Schechter, S. (1996). *Domestic Violence: A National Curriculum for Children's Protective Services.* San Francisco, CA: The Family Violence Prevention Fund.

Strategies for Administrators and Supervisors

Administrators and supervisors must work to support children, families, and—most importantly—staff. In many respects, the key to responding to young children who witness violence, and to their families, is for administrators to create the policy, fiscal, and organizational environment that will result in high-quality services. Working with traumatized children is stressful and exhausting. Teachers, childcare providers, and others who work with young children and their families in communities plagued by violence often experience burnout and fatigue. They might experience the same feelings as the children and families with whom they work, such as isolation, anger, sadness, and horror. Some of them might experience difficulty sleeping, eating, and concentrating.

Domestic Violence Programs and Services

Domestic Violence Services. Programs for battered women and their children frequently provide shelter, and they offer help to nonresidents, as well. Shelter services might include counseling, a 24-hour hotline, assessments and referrals of resident children, support groups, and advocacy for abused women with the courts, police, welfare offices, and job training programs. Nonresidential services often include support groups, referrals, hotline and crisis counseling, and advocacy for women seeking protection orders and benefits assistance. Domestic violence organizations frequently also offer community education and training.

Children's Advocates. Given that about half of shelter residents are children, and most non-sheltered battered women have children, children's advocates in domestic violence agencies coordinate services for children both onsite and offsite. Children's advocates serve as the link between families and other community systems addressing children's needs, such as childcare, schools, and Child Protective Services. They serve as a resource for other staff at the agency, educating and reminding them about children's needs. In addition, these advocates link children who have been victimized with children's advocacy centers.

Batterer Intervention Programs. These educational programs attended by batterers aim to change the abusive behaviors of domestic violence perpetrators. They hold batterers accountable, teach new skills that will facilitate changes in their behavior, educate them about the effect of domestic violence on partners and child witnesses, collect data on program effectiveness and recidivism, coordinate other required services, and report program compliance and noncompliance to the courts or other referral resources. Most of these programs are court mandated, but many accept voluntary participants.

Child-Witness-to-Violence and Other Treatment Programs for Children. These programs help children deal with the emotions and consequences that follow their exposure to domestic violence. They work to reduce problematic symptoms, strengthen children's relationships with their non-abusive caregivers, and help children and their families create and maintain relationships and living situations free from violence and abuse.

Victim Assistance Staff. These individuals might help victims to obtain injunctions or orders for protection, or to obtain crime victim compensation; help collect evidence; notify victims of hearings and accompany them to court; and provide other legal assistance and referral services.

Administrators and supervisors must be sensitive to the stress which their staff members experience, as well as to that experienced by the families and the children. This stress is usually reflected in the high staff turnover rate, which also results from low salaries, difficult working conditions, and the depth of need that providers see. It is reflected, as well, in the reality that some staff are coping personally with challenges similar to those faced by the parents and children they serve.

Administrators can play a key role in creating a more optimal environment for all children, families, and staff by implementing the following measures:

- *Create a supportive environment.* Build an atmosphere of trust and support among

administrators, consumers, board members, and others. Listen to the needs expressed by staff members. Increase staff comfort level and provide a safe forum for them to share their feelings, concerns, attitudes, and beliefs.

- *Provide training and resources.* Provide specific training to help staff members build their confidence in dealing with the emotional and behavioral challenges of the children in their care. Increase the capacity of staff with ongoing competency-based, culturally sensitive training related to domestic violence issues. Make clinical supervision and onsite mental health consultation available, and create forums for staff problem-solving. Promote staff peer-to-peer support and opportunities for fun and positive experiences.
- *Help staff prepare for emergencies.* Develop policies and procedures for responding to disclosures from children and parents, and for dealing with legal and other emergencies whether in the program, during the weekend, or when taking children on fieldtrips.
- *Help staff cope with stressful situations.* When a crisis occurs, ensure that staff members have the resources and support they need to successfully resolve the conflict and meet the needs of the children and families involved. Make professional help from a mental health specialist available for staff during and after a crisis.
- *Become part of a community response to families.* Join and provide leadership to community partnerships to promote closer collaborations between domestic violence and early childhood agencies. Develop close relations with resource and referral agencies, with child protective services, and with emerging networks of early childhood mental health consultants.

Building a Common Agenda

Many times, domestic violence services and early childhood education programs find themselves sharing the same families. Despite this, however, interaction between these two systems has traditionally been minimal, and mistrust has existed on both sides. There are many reasons for this. Some early childhood education staff members believe that battered women's advocates are exclusively woman-focused and regard the well-being of battered mothers as more important than that of their children. Many battered women's advocates, on the other hand, fear that by emphasizing the impact of domestic violence on young children, early childhood educators are encouraging the charging of women with failure to protect their children from the abuse perpetrated by the batterers.

Skepticism exists, as well, in both the early childhood community and the domestic violence community, about the extent to which mental health professionals can help. Members of the early childhood community worry that children will be needlessly labeled and stigmatized, while members of the domestic violence community doubt that mental health professionals understand how to react to the immediacy and urgency of the situation facing a family. Many are unfamiliar with safety plans and the dynamics of families involved in violence. In addition, efforts to build

collaborative relationships across early childhood and domestic violence agencies must deal with other predictable barriers (e.g., overburdened staff, worker turnover, lack of stable resources, competing goals within and across the agencies, and frustration at lack of services for the children and families).

Notwithstanding these difficulties for both systems, the positive outcomes for children and families are more likely to occur if there is collaboration between and among early childhood programs and domestic violence agencies. Some of the types of collaborations that are possible are highlighted below:

- *Joint Case Planning.* Early childhood and domestic violence staff members communicate about specific children and families, provide complementary services based on what each agency can deliver, advocate for families with the other agency, and do case planning with "dual system" families. At the most basic level, staff in both agencies can communicate informally about specific children and refer children and families to each other. But workers from the two agencies can also coordinate services for the same families and children (for example, doing one assessment) and develop specific policies to avoid duplication of services.

- *Joint Program Development.* Program development includes joint efforts by the early childhood and domestic violence programs to create new services. At the most basic level, agency staff members participate on advisory boards. Another program development strategy would be to have experts from both agencies provide cross-training in their area of expertise. More formal strategies can be to obtain funding to conduct joint projects that benefit both constituencies, co-locate services, and otherwise promote seamless services for young children and families.

- *Community and State Coalitions.* However important collaborations between early childhood and domestic violence agencies are, a need also exists for building coalitions and infrastructure that takes an even broader perspective to support young children and families affected by domestic violence. The many parts of a community that encounter these children and families, and the many state-level agencies whose policies and resources affect what happens to them, must be brought together. An opportunity also exists to expand state coalitions to ensure that they reflect the large numbers of young children and families who experience domestic or other violence.

Policy Recommendations

This paper primarily addresses direct service and collaborative strategies. But because the policy context plays such an important role in setting the framework for what local agencies can do and how much collaboration is possible, the five policy recommendations below should be part of an agenda to improve the lives and circumstances of young children and their families living with domestic violence.

1. ***Increase the resources meant to ensure that all young children (from birth through age six) have access to high-quality early care and education programs.***

   The data are clear that poor-quality early care and education programs are more common than higher-quality ones, especially for low-income children, toddlers, and infants. The need for increased resources to improve the pay and training of childcare providers is a critical issue for all children and holds especially important implications for children whose development is compromised by exposure to domestic violence and other risk factors.

2. ***Target specific resources to ensure that early care and education programs have access to specialized help so they can respond to special needs of young children and families affected by domestic violence and other significant stressors.***

   Targeted resources to support the kinds of strategies highlighted in this paper (e.g., partnerships with domestic violence services and early childhood mental health consultants, to help teachers and family support workers) are essential to overcome the harm of negative early experiences.

3. ***Include competency-based training on domestic violence and related risk factors in pre- and in-service early childhood professional development strategies.***

   In general, early childhood professional development fails to prepare teachers to deal with the risk factors that children bring to early care and education programs. States should review their current plans to ensure adequate attention to these risk factors.

4. ***Provide incentives and resources at the state level for community-based cross-training initiatives and collaboration.***

   Community-based cross-training strategies involving professionals and paraprofessionals with different perspectives as well as families constitute a powerful way to establish new relationships and knowledge that can facilitate effective services and responses to high-risk families. Such training can also be the basis for beginning to develop community planning and collaboration across the multiple systems—health, family support agencies, shelters, mental health, child welfare, TANF, substance abuse, police—that, in addition to early childhood programs, play a role in the lives of families affected by domestic violence.

5. ***Provide incentives to expand the cadre of social workers and psychologists trained to help parents, and of direct service workers trained to deal with domestic violence and other related risk factors.***

   Even when resources to provide consultation and support to the early childhood community exist, finding personnel with the right skills proves especially difficult. A federal workforce development strategy providing incentives to expand the number of clinicians and others with in-depth knowledge of the needed perspectives and

competencies related to domestic violence and young children and families would prove particularly helpful, although individual states can also create policies in this area.

Taken together, these five policy recommendations would greatly strengthen the community-level capacity for staff in both the early childhood and domestic violence communities—staff who work with such commitment to improve the real and hard lives of the young children and families they serve.

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Early Childhood
Domestic Violence
Poverty

Domestic Violence and Family Support Programs: Creating Opportunities To Help Young Children and Their Families

Series Paper #3

Introduction

Domestic violence affects families from every occupational, cultural and ethnic background. Because at least two million American families annually experience domestic abuse, most family support programs will encounter adults and children who live in daily pain or fear; in fact, most programs have probably already encountered these families, sometimes without knowing it.[1] Low-income families with young children appear to be at particularly high risk for such assaults.

Although domestic violence affects families across the economic spectrum and across cultures and communities, poor women and children are often the most vulnerable to its impact. Poverty can serve as a significant barrier for women who are in abusive situations—they may be economically dependent on the batterer; they may find the cost of setting up a new home and leaving the abusive situation prohibitive; they may not have friends and relatives with the economic resources to support them. They may feel that they must choose between leaving an abusive situation and feeding and sheltering their children.

Low-income immigrant victims may also face the possibility of losing their immigration status, or even deportation. If their legal status is derived through their partner they need to be able to demonstrate not only that abuse has occurred, but that deportation would result in extreme hardship (in order to get permanent residency status). The fear of deportation, either for themselves or their partners, is even greater for those who are undocumented.

For women seeking protection from an abusive partner the stakes are high. Women and men in minority communities may fear involvement in systems that their communities have historically mistrusted or viewed

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[1]This paper is based in part on conversations with family support programs across the country. These dialogues included informal conversations, visits to programs, focus groups with multiple programs, and telephone interviews. Thirty programs participated, and they represent a small slice of family support programs across the country. While the information is not intended to be representative of the state of family support programs' work in domestic violence, it does provide a snapshot of the themes and issues that came up in these conversations.

as racist—law enforcement, social services, child welfare, and immigration. Victims from these communities may feel caught between the desire to ensure their own and their children's safety, and their fear that by exposing the violence they risk being seen as not only betraying their partner but the larger community. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996[2] made conviction of domestic violence or stalking grounds for deportation, meaning that a woman's report of domestic violence may result in her husband's being deported.

> Domestic violence is a pattern of assaultive and coercive behaviors—including physical, sexual, and psychological attacks, and economic coercion—that an adult uses against an intimate partner. This pattern of serious assault is most typically exercised by men against a female partner and sometimes against their children.[3] These assaults are often repetitive and continuous and may leave women and children feeling dazed and bereft (Schechter & Knitzer, 2004, p. 4).

Although the level of risk in each family varies, domestic violence can have multiple and complicated effects on adults and children. It often impacts how parents care for their children, and how children respond to their caregivers. It affects the choices that family members are able to make, and the ways that they think about themselves. Domestic violence can increase children's risks for developmental difficulties and set them back. It sometimes leads to physical injuries and almost always to emotional anguish. Yet while the impact of domestic violence on children, whether or not they themselves are victims of violence, is real and often palpable, a surprising number of children show significant resiliency in the face of this violence. One of the factors that seems to determine a child's resilience is the existence of a secure attachment to a caregiver (Gewirtz & Edleson, 2003). This points to the importance of supports and strategies that help to maintain and even strengthen the connection between children and their caregivers in the face of violence or while violence is being addressed. Low-income and vulnerable families may find a family support program particularly helpful as they deal with domestic violence, because it can offer them access to resources and responses to the violence that are seen as less intrusive and remedial.

This paper offers recommendations to family support staff and administrators. It is particularly designed for programs that are beginning to work on domestic violence. It includes the following:

- Specific ways to prepare staff to address domestic violence
- Suggestions for supporting families
- Policy and programmatic recommendations

[2] Public Law 104-208 (1996). HR3610.

[3] Because the most serious forms of adult domestic violence are carried out by husbands and male partners, the term "battered woman" is used in this document to refer to the adult victim. However, lesbians and heterosexual and homosexual males are also victims of the kind of abuse described in this document.

Family Support Programs

Family support programs share a common approach to their work: they are community-based and strive to be flexible and responsive to the needs of the specific families and communities they serve. Each program varies from the others in the kinds of services offered, and in its structure and setting. Most share the following characteristics:

Services

- Parenting education
- Child development activities
- Parent-child activities
- Peer support
- Access to social services

Philosophy

- Strengths-based as opposed to problem-oriented
- Peer-to-peer support
- Non-stigmatizing
- Community-based
- Prevention vs. crisis oriented
- Work with the whole family
- Focus on families' and communities' cultural strengths

Focus

- Support parents in the job of parenting
- Strengthen families
- Promote positive child development
- Help connect family members to larger community
- Meet needs

Family Support in Child Welfare and Other Settings

Over the last 15 years there has been a movement at both state and federal levels to infuse family support practices and philosophy into other programs—child protective services, alcohol and substance abuse treatment, juvenile justice, and welfare. While these programs may be different from traditional family support agencies—some work with mandated families; some are not peer-based—they generally share a strengths-based perspective and commitment to developing a respectful and supportive relationship with the family.

Family Support Programs: Responding to Families Experiencing Domestic Violence

Family support programs possess unique strengths and also face challenges in designing interventions for domestic abuse. Their key strength is the strong and trusting relationships that are built between families and program staff. Because of their peer-to-peer emphasis and their strengths-based perspective, family support programs tend to engender strong, supportive ties among families using their services. These relationships open the door for program participants to disclose details about domestic violence and to seek assistance.

Another strength of family support programs is the broad array of services they make available to families. People tend to think of domestic violence response in terms of intensive services such as shelter, legal assistance, and police and court advocacy. Many families need other kinds of

help—for example, peer support, such as groups and buddy programs; income and employment advocacy; housing and medical assistance; and child care and other parenting supports—sometimes before they are willing or able to access more intensive domestic violence services, and sometimes instead of them. Strong family support programs not only provide a number of these services but also have experienced staff who can advocate for families with more intensive service systems. This type of advocacy may be especially important for those families who feel that there are barriers to accessing these service systems—either because of language issues, or because of historic mistrust between their communities of identity (or of place) and these service systems.

Because family support programs focus so much attention on family life, they bring another key asset to the arena of domestic violence: their commitment to strengthening parents. Domestic violence can fundamentally erode positive family interactions. Adult victims may experience depression, stress, isolation, and loss of self-confidence, which, in turn, may affect the ways in which they care for their children. Abusers sometimes inflict violence on their children as well as on their partner, and they create a tone of anxiety within the household that impacts not only victims but also children. Children who have witnessed domestic violence often experience anxiety, guilt, anger (at one or both parents), and emotional distress that affect their school behavior and their social relationships. For young children, there may be developmental regression, such as problems with speech or bedwetting. Exposure to violence may also contribute to problems with attachment that impact a host of developmental outcomes, including emotional development and readiness for school. While parenting support by itself will not solve the problem of domestic violence, it can be an important part of keeping family members strong and stable as they try to end the violence and minimize its impact on children.

Finally, the family support program's strong connection to the community in which it is located is a key asset when addressing issues of domestic violence. Relationships with community institutions and resources mean that staff can draw together a comprehensive array of supports to wrap around a family experiencing violence. They can also serve as a host and convener for conversations and dialogues about the issue of domestic violence and the task of building community norms and values that address the issue.

Like many other crisis issues, domestic violence presents challenges to family support programs. Many family support programs provide informal peer-based help rather than intensive intervention services. Responding to a domestic violence crisis may require the family support program to work in new partnerships with a host of other services. The family, however, may not be ready or willing to use these other services or to deal with the violence directly. As a result, family support programs will face the challenge of juggling a number of competing priorities:

- *Maintaining a strong, supportive, and respectful relationship with the family.*
- *Encouraging family members to recognize that they may need outside supports to address the issue of violence.*

- *Helping family members to negotiate systems that may not be family supportive in their orientation.*
- *Addressing the safety of all family members even if the family avoids the issue.*
- *Recognizing that the needs of family members may be different and competing, and that there may be a need to "choose" between these competing needs.*

Dealing with domestic violence can bring up philosophical tensions for family support workers who view families, and parents in particular, as the experts in defining their families' needs. The strong relationship between the worker and family is, in part, forged through a commitment to uphold the family's wishes. Yet in the case of domestic violence, the worker may feel a strong conflict between honoring the family's desires and trusting his personal assessment of what the family needs. This conflict is strongest when the worker is worried about safety.

Philosophical tensions may also come into play when workers interact with an abusive family member. Batterer interventions in the domestic violence field are largely predicated on the assumption that batterers will not change without some sort of coercive mandate—whether that is court-mandated services, or a partner who threatens to end the relationship unless the abuser seeks help. Additionally, many batterer programs confront the abusive person about the violence as a way of motivating a change in behavior. Family support programs generally operate under a different theory of change in which voluntary participation in a program is essential for success, and all approaches to change are strengths-based.

Family support's theory of change also focuses on working with the entire family; in fact, the family support field criticizes other models of change for ignoring the reality that the individual exists within a family and community system. Within this framework, working with an abusive partner is an important part of effectively helping the family. Yet, this work is difficult, delicate, and fraught with uncertainty. Workers do not want to make the situation worse or more dangerous—yet the appropriate course of action to best ensure safety is not always clear. In some cases it may mean involving the abusive partner as an active player in family decision making, thereby reducing any sense that his needs and desires are being ignored. In other cases, this type of direct engagement with the batterer may cause him to feel that his control in the family is being challenged. In some families, outside pressure from the extended family or friends can help to stop or mitigate abuse. In others, it can exacerbate the situation and increase danger. Navigating these situations is a challenge that requires collaboration with experts in domestic violence and batterer intervention, fields that may view the goal of work with batterers as changing the individual, not engaging the family.

Preparing the Family Support Program To Address Domestic Violence

Addressing domestic violence effectively requires preparation. Too often, programs wait until they are faced with a family in crisis. This lack of preparation can waste time, lead to poor referrals, and fail families.

Step 1: Assess the prevalence of and attitudes toward domestic violence in the community and among the families served.

Most family support programs confirm that they encounter domestic violence, although it is most commonly reported by those agencies working with high-risk families. For example, Cornerstone, a family support and job-training program for families on TANF in Cedar Rapids, Iowa, reports that 84% of those served are past or current victims of domestic violence (G. Hemmingson, personal communication, February, 2002). Asian Perinatal Advocates in San Francisco, which provides family support to Asian families with newborn children, estimates that approximately one quarter of all families they serve—and about 50% of the Filipino families—experience domestic violence (M. Ho, personal communication, November, 2001).

Understanding the prevalence of domestic violence will help to guide the response that each family support agency designs. While staff in all programs should have the capacity to recognize and respond to a domestic violence crisis, programs that are working in communities with a high incidence rate may want to increase the types of interventions that they offer.

Identifying community and cultural norms about violence, male and female roles, parenting, and separation and divorce is also crucial. These norms not only influence the rates of domestic violence, but they also help to determine the interventions that families will accept and community groups will offer. It is important to note that within communities these norms vary and differ, and it is important not to take the point of view or perspective of one particular community informant or institution as indicative of the values and attitudes held throughout the community.

Also, assess the community's readiness to discuss the issue of domestic violence. Talk to community leaders and key informants. Find out which institutions and individuals are already

Defining Community

Most family support programs serve a discrete physical community where they are located—yet defining the community they serve is often much more complex. Within the physical community they serve there may be a number of existing ethnic and cultural communities with distinctly different norms, values, and experiences. For programs that serve particular ethnic and cultural communities, while they may be located in a geographic community where there is a high concentration of the population they serve, program participants may come from well outside of the geographic area to receive culturally relevant services. Finally, there is the reality that different ethnic groups and cultural norms exist within communities. So, for example, in the South Asian community there are significant cultural differences based on country and region of origin, age, assimilation level, religion, politics, and a score of other factors. Any family support program working with a community needs to be mindful of these complexities and explore the many different communities encompassed in the community they serve.

Source: M. Ho, personal communication, November, 2001

addressing issues of violence and which are not. Learn more about how violence is currently being addressed in the community. What are the barriers to discussing violence within the community? What are the ways in which violence is discussed?

Strategies for your program:

- *Find statistics on the prevalence of domestic violence either in your geographic community or in population groups (racial, ethnic, income, etc.) similar to those who live within your community.*
- *Recruit a group of community residents to survey their neighbors about their experiences with violence and with seeking help.*
- *Hold focus groups with diverse groups of community members about community and cultural norms about domestic violence—include some specific focus groups with populations experiencing high rates of violence.*
- *Convene a dialogue with religious, ethnic, community, and political leaders.*
- *Conduct key informant interviews with those who represent different points of view within the community.*

Step 2: Get to know the domestic violence network in your community.

Ideally, staff should have an opportunity to visit local domestic violence agencies, get to know front line workers, and learn how the referral process works for families.

Staff may need to be creative in their approach to identifying resources for families. This is especially true in rural communities where there are often no domestic violence services. In contrast, in large urban communities there are often domestic violence programs that are designed to address domestic violence in specific cultural communities. As programs develop their resource list, they might consider identifying the following forms of assistance for families:

- Resources to help deal with the violence and to provide immediate safety—domestic violence programs, law enforcement agencies, legal aid offices—and medical assistance, and batterer intervention programs.
- Resources for emotional stability—counseling programs provided by staff who are trained to help trauma survivors; domestic violence support groups; child-witness-to-violence programs.
- Resources to maintain financial stability—housing supports, job training, and employment assistance.
- Resources for specific ethnic or cultural communities—these may be domestic violence-specific programs, or other culturally specific programs in the community.

Questions to ask about domestic violence services:

- What supports are available for families?
- Does the organization provide advocacy for court, housing, and for TANF and other financial services?
- What services are available for children?
- Are there multicultural and multilingual staff available?

For residential services:

- Can victims bring their children, and are there any restrictions on this? (Many shelters do not allow teenage boys.)
- What is the maximum stay?
- How easy is it to get a bed? (Is there a waiting list?)
- What are the rules for residents?
- Are there multicultural and multilingual staff available?
- What services exist for families and children in the residential program?

Strategies for your program:

- *Create a book for your staff on domestic violence resources in your community. It should contain information on hours, services, referral protocols, and contacts.*
- *Use focus groups and conversations with families to assess how these resources are perceived within the community and whether families experience them as welcoming and supportive.*
- *Provide staff members opportunities to visit these programs so they have a chance to observe the environment into which they are referring families.*
- *Invite staff members from the programs to provide brief in-service education for your staff.*
- *Offer information about the family support program to the domestic violence agency.*
- *Make information on domestic violence resources available to program participants.*
- *Identify possible partnerships—domestic violence services, like many others, are underfunded, and client needs far outstrip resources. Partnering with domestic violence programs to provide parent education, support groups, or children's activities can bring family support services to a population that could benefit from them.*

Step 3: Decide what your agency's role and approach will be.

Once the family support agency has conducted a needs assessment and identified domestic violence resources in the community, it faces two key questions: what role does it want to play, and what resources does it have available? Some family support agencies may decide that their role is to inform families about existing domestic violence services in the community and facilitate

their access to help. Other programs may want to add staff training and services specific to supporting families and young children who are experiencing domestic violence. Still others may find that the local domestic violence program wants to build a partnership around a specific initiative. At a minimum, every family support program should expect its staff to respond to adult victims and children in ways that foster safety, provide support, feel culturally supportive and respectful, and make appropriate referrals.

Cornerstone, Cedar Rapids, Iowa

Cornerstone, funded through a Family Development Self-Sufficiency grant (FaDSS), is designed to provide intensive, in-home family support services to help high-risk welfare recipients work toward self-sufficiency. Cornerstone family support workers make home visits to assist families in overcoming barriers to entering the workplace. Recognizing the pressure that domestic abuse puts on participants, Cornerstone staff place domestic violence work front and center. Initially, the program expected that its family support workers would refer families to domestic violence services within the community. Workers were provided in-service training to help them recognize signs of domestic violence and make appropriate referrals. Cornerstone staff found, however, that families were reluctant to accept referrals and preferred to seek help from their existing family support worker. Workers realized that they needed more tools and skills to provide the in-depth support that these families were requesting. Through the Cedar Rapids domestic violence agency, Waypoint, Cornerstone family support workers and Waypoint domestic violence advocates receive the same training. Training gives the family support worker the capacity to do the following:

- Assess the violence and its impact on family and individual functioning.
- Develop a safety plan with the victim.
- Learn supportive ways to talk to the victims without blaming them, telling families what they should do, or giving the impression that the violence is condoned.
- Connect families to concrete resources to end the violence—housing, social services, mental health counseling, employment, and informal supports.

Source: G. Hemmingson, personal communication, February, 2002.

Strategies for your program:

- *Convene a meeting with staff, board members, and program participants to review the results of the needs assessment.*
- *Brainstorm possible programmatic directions, and envision the role with regard to domestic violence that the family support program wants to take in the community.*
- *Meet with the local domestic violence programs and other community partners to share your ideas.*

Step 4: Train staff.

No matter what role the program chooses to play, every staff member should have some basic knowledge about domestic violence. While programs may offer more intensive training to staff members who provide one-on-one intervention with families, every staff member—from the receptionist to the child care worker—should be able to respond appropriately when confronted with the issue.

The following basic training topics should be covered:

- Identification of domestic violence
- Supportive questions to ask if you suspect abuse
- Effective ways to talk to batterers
- What to do if someone discloses abuse
- Effective ways to offer support and safety to adults and to children
- Domestic violence in a cultural context

Staff who work one-on-one with families will benefit from more in-depth training. Ideally, this training will help them to build the strong and supportive relationship that can be used to encourage the family to connect to domestic violence resources in the community. This can be a long-term task, as families experiencing domestic violence are often extremely isolated and wary of new individuals and organizations that might make an already fragile situation worse.

The following topics should be covered in in-depth training:

- State domestic violence laws and how they are interpreted and applied by police, the court system, and child welfare agencies in the community.
- Assessing domestic violence and its emotional and material consequences.
- Understanding patterns in response to violence—why women stay, leave, and return.
- Working with victims over time—developing a safety plan and understanding family support needs.
- Working with the family when the batterer is involved.
- Engaging with batterers during home visits and family meetings without endangering victims.
- Working with children who have witnessed violence: what family support programs can do.
- Understanding and responding to the needs of young children.
- Advocating for families and for children in multiple systems: court, welfare, housing, mental health, and child welfare.
- Maintaining the worker's own safety.

- Working with the intersection of domestic violence and other family needs—especially poverty, homelessness, child abuse and neglect, substance abuse, and mental illness.
- Helping clients explore culturally appropriate responses and resources.
- Cultural issues as they impact domestic violence—and how to use cultural tradition as a tool for addressing and healing from violence.
- Working with families over time to overcome the barriers that may keep victims from leaving an abusive relationship—including helping victims to overcome the material hardships that may be caused by leaving (loss of housing, loss of income from the abusing partner, loss of insurance and other benefits, etc.).

Strategies for your program:

- *Review existing training. Is domestic violence covered?*
- *If training needs to be supplemented in the area of domestic violence, identify a partner organization in your locality that can help. Your state domestic violence network can give you information about programs in your area that provide training. The National Resource Center on Domestic Violence also offers many training resources.* See http://www.nrcdv.org/
- *Assess the proposed training curriculum—does it provide staff with the concrete skills they need? Is it family supportive in its nature and orientation? Is it culturally sensitive and appropriate to the population your program is serving? Does it include training on understanding culture, cultural self-awareness, and culturally sensitive assessment, as well as culturally appropriate responses on all of the topics covered? Does it give staff concrete skills for supporting families from different backgrounds?*
- *Support staff with case consultation and supervision to follow up on the training and to determine behavioral change. Within the supervisory relationship, staff can explore topics of race, culture, and acculturation in order for the staff to reach a common understanding of key concepts of providing culturally competent services.*

Supporting Families

Raising Community Awareness About Violence

Preventing domestic violence means going beyond work with individuals. Using its role as a convenor within the community, the family support program can create a broad awareness of violence—and a broad ownership for disavowing it. To do this, the family support program must first communicate its stand that violence is unacceptable. Conversations within the community about abuse and its impacts aid the following purposes:

- Encourage an examination of attitudes which serve to condone violence.
- Send messages to perpetrators that violence is unacceptable.

- Help victims to feel that support is available.
- Encourage local actions around violence.
- Build support for responses to violence.
- Explore issues of how racism, oppression, and societal violence contribute to domestic violence.
- Build support with community-based groups which provide support for different minorities.

Círculo de Liderazgo Familiar

On December 7, 2001, an abused woman was stabbed to death by her husband in front of their 11-year-old daughter in Pilsen/Little Village, a primarily Latino community in Chicago. Outraged, the women in the neighborhood sought the support of several groups, including Círculo de Liderazgo Familiar, Saint Pius Church, Chicago Connections, and the Chicago Abused Women Coalition. The women organized a march to "break the silence" about violence against women and to increase community involvement in domestic violence prevention. Since then, a group of Círculo's Leadership Program graduates have conducted a series of meetings to find new ways to intervene in and prevent domestic violence in their neighborhood.

Círculo is a popular education model that fosters a continuous dialogue to promote critical thinking and consciousness-raising. Twenty program graduates and community members form a volunteer base to facilitate parenting courses, leadership development trainings, and domestic violence self-help groups. Using popular education methods and participants' experiences, they explore issues such as gender bias, racism, violence, and power. Participants are encouraged to analyze these issues with the goal of developing strategies for community change. Counseling is also offered for families and individuals, and child care is provided to them. Services are delivered at three local parishes.

Círculo is now seeking funding to

- build a grassroots network of women who will respond to domestic violence survivors in their homes,
- develop women leaders who advocate for domestic violence services and systems that are responsive and accountable to the community, and
- raise awareness in the community about the social and political aspects of violence prevention for Latino families.

Source: S. Puente, personal communication, March, 2002.

Strategies for your program:

- *Start with a conversation among staff—staff should be cognizant of their own attitudes and biases about domestic violence before they work on this issue.*
- *Review existing programming. Are there places where discussions of domestic and community violence can be woven into existing content? Programs might incorporate conversations about violence and power as a standard topic in parenting classes, or consider integrating*

domestic violence into life skills courses on conflict resolution, anger management, stress, and interpersonal relationships.

- *Create an environment where domestic violence can safely be discussed within existing support groups.*
- *Invite staff from the domestic violence program to be guest speakers for support groups and parenting classes.*
- *Use examples of violence by media figures or from television shows, pop songs, or movies as opportunities to initiate conversations about how violence is woven into the fabric of our society.*
- *Convene community dialogues around domestic violence—invite service programs, local leaders, and neighborhood residents. Depending on the community you serve, you may also want to convene individual dialogue sessions for specific ethnic or cultural groups within the community, or other specialized groups—for example a dialogue just for teens, or for those in same-sex relationships.*
- *Encourage children to speak out and examine societal attitudes about violence. Organize discussion groups, theater presentations, and other educational events.*

Creating Space for Cultural and Ethnic Communities To Discuss Issues of Domestic Violence

Violence against and control of women is embedded into the cultural history of most cultures and religions. Similarly, in every culture there are progressive movements trying to change these attitudes. In many communities there can be a perceived tension between the need to address these issues and to change values, on the one hand, and, on the other hand, the need to maintain cultural continuity, especially among cultures that are facing histories of colonization and displacement. This tension can be exacerbated in communities which face stereotyping around this issue—the Muslim community, for example. Activists from within the community who are concerned with the rights and treatment of women may be silenced because they do not want to appear to contribute to the demonization of the community. Activists from outside the community can be perceived as "missionaries" seeking to attack the community's structure and values in their zeal to address the issue of violence.

A safe space needs to be created for those within a community to discuss and address the issue of violence. Whenever possible, conversations about the issue should be convened and led by members of the ethnic or cultural community. Efforts should focus not only on a critique of cultural practices that contribute to violence, but also on the positive cultural traditions that are a foundation for addressing violence.

Creating a Safe Space for Victims Within Family Support Programs

Victims often need a space in which they can explore the possibility of getting help. Initially victims may be reluctant to talk to anyone about the violence. Access to a safe and comfortable setting—without pressure to disclose—may be an important first step in help-seeking.

Strategies for your program:

- *Provide information on domestic violence services in a place where a person can pick it up without being observed—many programs keep brochures for domestic violence programs in the restroom.*
- *Make sure that books and resources on domestic violence, for adults and for children, are available in the center's library or resource room.*
- *Allow victims to call domestic violence programs from a private phone within your center, or to meet with domestic violence advocates at your program site.*
- *Create an open door policy—set times when parents know they can speak with a staff member privately, without having to set up an appointment or compete with other families for attention.*
- *Make materials available in the languages of the populations being served.*

Responding to Families Experiencing Domestic Violence

This section offers suggestions to family support workers as they try to assist families who are dealing with domestic violence. As with all family support practice, there is a need for a strengths-based and culturally respectful approach that works on several levels to respond to a family's experiences, needs, goals, values, and beliefs, and to encourage families to take the lead in defining their needs.

The first step is to be proactive. Workers should be alert to signs of domestic violence and prepared to inquire about violence. Although asking about violence may be uncomfortable for the worker, and the victim may be unwilling to disclose what is going on, the very act of asking sends the message that someone is concerned, and that the violence can be addressed.

The worker should keep these points in mind:

- *Speak to the victim privately. Asking about domestic violence in the presence of the perpetrator—or in a way that alerts the perpetrator to the conversation—can put the victim at risk.*
- *Voice concern for the victim. Tell her that you are there to listen and support her, whatever she ultimately decides to do.*
- *Explore the nature of the violence and the level of threat and danger which the victim and her children face (Appendix A includes a set of assessment questions).*
- *Assure the victim that any information she divulges will be considered confidential—with the exception of information that indicates that a child or another family member is at serious risk of harm.*

- *Explain that you are required by law to make a child protective service report in cases of serious risk (see Appendix B).*
- *Try to determine whether the abusive partner has ever harmed or threatened to harm the children. If he has, inquire about the frequency and extent of these incidents. Explain to the victim that you need to work together to ensure the safety of the children.*
- *Explain the impacts that domestic violence can have on children. Ask about effects on the child, and offer help for the child in the context of building upon the parent's strengths and concerns.*
- *Help the victim to think through her existing support system. To whom can she turn? Whose response would she be afraid of? Are there issues of disloyalty to family and community that may make her reluctant to address the violence?*
- *Encourage the victim to connect with a domestic violence program or with an agency that specializes in counseling and advocacy for survivors. Offer to accompany her if she wishes, while being sensitive to local protocols and the confidential location of some shelters.*
- *Provide her with a written list of resources in the community—for safety, for meeting basic human needs, for accessing benefits.*
- *Help her develop a safety plan that she can follow if the violence escalates or if she is afraid for herself or her children.*
- *Encourage her to get involved in support groups and other activities that will reduce her isolation.*
- *Connect her with parenting support. (See box on next page.)*
- *Make sure the victim is connected to resources that can help her to process her own feelings of shame, fear, disloyalty, and other emotional responses both to the violence and to taking action to end it. Such resources might be the family support workers themselves, a member of the victim's own social support network, a domestic violence support group, a religious or community leader, or mental health or counseling resources.*
- *Make sure that those resources have a clear enough understanding of and experience with her cultural context to be able to provide support in a sensitive and appropriate way that expresses respect and support for her values and traditions, as well as a clear understanding of domestic violence and the context of domestic violence.*

Remember that when victims first disclose domestic violence they are often not prepared to leave—and many victims never choose to leave. Staff should be prepared to support families in whatever choice they make. It is particularly important to avoid isolating and undermining the victim further, blaming her, or getting angry with her. The most important service that family support programs can provide to victims of domestic violence is to increase their sense of autonomy and to restore the control that violence strips from them.

Providing Parenting Support to a Victim of Domestic Violence

- Help the victim to understand the impact that violence can have on her children and their development (see Appendix C). Protecting children is a significant motivator for victims of domestic violence to take steps to enhance safety.
- Talk with the victim specifically about the ways in which the abuse affects her responses to her children.
- Create strategies to address her concerns about her children, i.e., making sure that the kids are getting extra reassurance, that the parent is helping them process their responses to the violence, and that there is someone to take care of the children if the mother is injured.
- Help the adult victim to explore concerns about the batterer's discipline of the children, unsupervised access to them, and visitation or custody problems. Make sure the mother has proper legal advocacy and counseling support for her children, if it is what she wants.
- Help the victim to explore her cultural context and how this impacts her, her children, the batterer, and the ways in which they interact about the violence. Make sure that any parenting supports provided are respectful of her culture and tradition.
- Help the victim to explore issues of parenting as they relate to the batterer. How does the batterer parent? What are the impacts on the children? Help her think through issues of co-parenting and what it will mean for the children—and for her own safety.

Working with children affected by domestic violence

Domestic violence can have a significant impact on children. Studies show that children are often far more aware of the extent of the violence than their parents realize. Exposure to violence can raise children's anxiety and disrupt their sense of safety and stability. Children exposed to violence may be more aggressive and more likely to see violence as an appropriate means of resolving conflicts with others (Edleson, 1999). Children who are exposed to violence often have special emotional and developmental needs to which programs must attend.

Additionally, there is a high correlation between domestic violence and child abuse and neglect (National Clearinghouse on Child Abuse and Neglect, 2001). Violence from the perpetrator is sometimes directed at his children as well as his partner. Some victims of domestic violence experience extreme stress and significant depression, which may impact their ability to parent effectively and contribute to abuse and neglect. In fact, 37% of battered women have symptoms of depression, and 45% experience post-traumatic stress disorder (Housekamp & Foy, 1991). Many children and parents are resilient and able to adjust to the violence in ways that permit them to develop healthily and maintain strong parent-child relationships. Still, it is important to be aware of the danger of violence to the child, and to reach out and provide extra support for child and parent.

Jewish Children and Family Services (JCFS)—San Francisco

JCFS has created a model of mental health consultation for low-income child care and family support centers in San Francisco's Bay Area. The mental health consultant provides clinical services to the referred child and/or family, such as on-site therapeutic groups, neuro-developmental assessment, and on-site or at-home dyadic child-parent psychotherapy. Mental health consultants are available on site to child care staff, if they have a concern about a particular child or family. The mental health consultant offers the staff advice about how to respond to the individual child and family's mental health needs and about ways to better integrate mental health concerns for all families. The result is that staff have more confidence and better skills in recognizing and responding to distressed children and their families.

Source: A. Rassen and L. Kloomok, personal communications, November, 2001.

When working with young children, keep in mind the following:

- *Make sure that there is a single adult in the program that connects with the child on a regular basis and encourages the child. Make sure the child knows that he can come to that individual if he is scared or needs help.*
- *Work with the parent to make sure that a young child can understand any safety plans that have been developed. With very young children, help the victim to think through how she can quickly and safely leave with the child if need be.*
- *Make sure to create a secure and nurturing environment for the child within the family support center. Give the child ways to express emotions related to the violence; this can be through art, writing, play, or conversations with an adult. For young children, make sure that they are connected to an adult who can provide warm and nurturing care.*
- *Connect the child to supportive mental health services such as play therapy or mental health counseling if your staff or the parents have concerns about symptoms of distress that persist for more than a couple of months. Note that for many poor families, affording access to mental health services is difficult. Building relationships with local providers who are willing to provide services for free or reduced rates may be helpful.*
- *Provide extra support and structure for the child when he is participating in programmatic activities.*
- *Be mindful that there are a variety of ways in which children who are exposed to violence can behave. These can include increased aggression against other children and animals, withdrawal from activities, increased irritability, and developmental regression.*
- *Interaction with children must also include sensitivity to linguistic and cultural differences in children's programs. Also, where assessment tools are used, they should help staff to see the child from different angles, including that of his or her cultural and familial background. This is an*

important issue with children showing atypical behavior—in order to be able to distinguish between developmental delay and a cultural difference.

- *In some cases there may be a conflict between the mother's opinion and desires and what the worker thinks that the child needs. Watch for impacts on the child's development, and help the mother to understand these signs. Where staff have concerns that the violence is significantly impacting a child's development, they will need to raise those concerns strongly to the victim. If the concerns are not addressed, or there are signs that the child himself is being abused, a child welfare report may be warranted (see Appendix B).*

Working with the person who batters

In some cases, a victim or a batterer may ask program staff to intervene to stop the violence. Two questions need to be answered by the program before this work begins. First, should family support staff intervene in this way? And second, if there is to be an intervention, what work should be done, by what staff, and with what training?

Before attempting to do any work with a batterer, the worker always needs to talk openly and frankly with the victim, in private, about the possible impact that this will have on her and her children's safety. If the victim considers this idea to be dangerous, it should be abandoned, and other avenues for helping family members should be explored. Program staff should also make sure to check in with the victim regularly about the impact of any interventions on the level of violence in the home. If there are any concerns that the violence is escalating and/or the victim and their children are not safe, program staff should work with the victim to develop a plan that will ensure her safety. This may mean ceasing work with the batterer, connecting them to a different type of interventive service, or another response.

In considering interventive work with batterers, it is important that family support staff are in dialogue with both domestic violence programs and batterer programs. The family support program might convene a multidisciplinary planning group in its community, consisting of other service providers, including the batterer intervention, domestic violence, and fatherhood programs, if they exist. Some states have set guidelines for providing intervention services for abusive partners, and the local program needs to be aware of them. A committee might help the family support program spell out its role—and understand better the other community supports that the family can draw on. For instance, a family support worker might play a very important part in talking to a batterer about his abuse, its impact on his children and partner, and encouraging him to join a batterer intervention group or to go to treatment for contributing problems, such as substance abuse. The family support worker can also assist the batterer by helping him to meet his basic needs for housing or job training.

Local domestic violence experts might also offer the family support workers training so they feel more comfortable as they talk with an abusive person or encourage him to get more specialized help. Consultants and key informants from the ethnic and cultural communities the program

serves can provide important information for understanding the context within which the violence is occurring and offer strategies used within the community for addressing violence.

In considering work with batterers, the family support program is trying to balance two concerns. On the one hand, the agency wants to avoid making the violence worse, and on the other, it needs to acknowledge the seriousness of assaults and threats against family members. Each program will have to assess each family's circumstance—the level of risk and protective factors—in order to make good intervention decisions.

When working with batterers, keep in mind the following:

- *Support the batterer's effort to get help—while sending a strong and clear message that violent and controlling behavior is never acceptable.*
- *Connect the batterer to a batterer intervention program in your area. (See box with criteria for evaluating batterer programs. The quality of programs varies widely.)*
- *Refer the batterer to programs and services that can help him deal with other issues—for example, substance abuse, unemployment, or mental health concerns—that may be affecting the violence.*
- *Continue to work with the victim on safety planning—even if the batterer has entered treatment.*
- *Connect the batterer to other men from his cultural background who can help him to explore non-violent and non-controlling ways of being in a relationship.*

Criteria for Evaluating Batterer Programs

- The primary goal is to end the violent, abusive, and controlling behavior.
- Abusers are held accountable for their behavior.
- Provisions are made for the safety of battered women and their children.
- The batterer program collaborates with other agencies in the community to stop the violence.
- Clients of the program are treated respectfully.
- Multicultural and multilingual staff are available.

From: Bonnie Brandl, "Programs for Batterers: A Discussion Paper." Division of Community Services, Bureau for Children, Youth and Families, U.S. Department of Health and Social Services. August 1990.
http://www.nmsvdv.org/batterer.html

Working with a victim who wants to leave a violent situation

If the victim indicates that she wants to leave her partner, help her make a plan to accomplish this. Most often victims leaving an abusive situation turn first to their informal network—family members, friends, and church groups. In many ways these informal resources can provide the emotional support and continuity that is crucial at such a difficult time.

Staff should confer with the victim, keeping in mind the following points:

- *Help the victim think through who is in her network and how they would respond if she came to them for support. Would they be able to provide her with money, shelter, child care, emotional support? Would they be willing to withhold information about her whereabouts from her partner?*
- *If there is no one in her network to turn to, or if she faces serious danger, help her to identify possible shelter and legal options. For some women, leaving is a very dangerous prospect, and a very dangerous moment, and careful planning is required.*
- *Ask her how and when she can most safely leave. Does she have transportation and money? Provide her with resources, if possible.*
- *When needed, program staff should serve as "cultural brokers" with other services. For example, non-English-speaking children and families may need access to translators, non-verbal and culturally appropriate assessment tools, and printed materials in the family's own language.*

Once the crisis of leaving is managed, it is important to work with the victim on a long-term plan for weathering the profound disruptions in her life. These tasks for staff may include the following:

- *Help the woman file for divorce or get a protective order against the abuser. In many cases, completely cutting off the relationship is impossible because of court-ordered child visitation and other issues that necessitate contact. Domestic violence services and family support programs can help the woman develop safety plans for these continuing contacts with the batterer.*
- *Help her to achieve economic self-sufficiency. Helping the abused person to develop a long-term plan for financial stability is an important part of building her confidence that she can make it on her own. This assistance can include credit counseling, job training, or access to public benefits.*
- *Arrange for emotional support for her and her children. Leaving an abusive partnership is traumatic, both for the abused spouse and for the children. It is important to help the victim think through her sources of emotional support. Connecting her to services that can help her to make the transition is also important—counseling, support groups, social activities, parents' groups, and services for children.*
- *Think through the protocols if both the victim and the batterer want to continue using the program. If the batterer is dangerous, the center may need to consider getting a protective order*

that requests that he stay away from the program. In other cases, staff might simply negotiate with both so that victim and batterer use the program on alternate days.

Supporting program staff

Domestic violence is also difficult for workers. Their close relationship with the family may lead them to feel emotionally vulnerable, anxious, frightened, and angry about the violence. Workers may be perceived as a threat by the perpetrator, and therefore become a target of his rage. Workers also may be invested in convincing a victim to leave her abuser only to become angry or upset if she refuses or later returns to the perpetrator. Family support workers will need good colleagues and supervisors to help them in these moments.

Keep in mind these strategies for your program:

- *Provide extra supervision and support to a worker who is helping victims of abuse. Make sure that the worker can talk to someone who is knowledgeable about domestic violence.*
- *Make sure that the worker is safe—this is particularly important for home visitors.*
- *Make sure you are attuned to your staff. Be sure that the climate for revealing issues related to violence in their personal lives is as non-judgmental and supportive for staff as it is for families.*

Recommendations for Policy and Practice in the Field

The following section looks beyond individual programmatic practices and makes recommendations for how the family support field can develop infrastructure to support programs working in this area.

Practice

1. ***Incorporate violence-free principles and activities as part of the core mission of family support programs. Family support programs should build their capacity to prevent family violence and respond to child and adult victims through staff training, incorporation of new program activities, and community linkages.***
2. ***Provide funds to family support programs, to domestic violence programs, or to the two types of programs jointly, to explore collaborative, community-based activities to prevent family violence and to respond to child and adult victims as well as to batterers. Collaboration could bring needed new resources to families with young children in the shelter system, such as providing parenting education, parent-child activities, and other services to strengthen the parenting skills of victims.***
3. ***Provide resources to explore how to work effectively with batterers in family support programs.***

During interviews conducted for this paper, family support staff reported that they felt most uncomfortable—and had the least guidance—about work with batterers. It was also the area in which family support practice seems to be most in conflict with standard practice in the domestic violence field. The knowledge base about working with batterers needs to be built and applied to a family support context. Basic guidelines for interacting with batterers in ways that are least likely to exacerbate the violence also would be useful.

Training

1. *Ensure that staff of family support programs are included in training about domestic violence, its impact on children and adults, and appropriate responses for both victims and batterers.*

2. *Ensure that training funds for family support programs allow for reimbursement for consultation with experts trained in domestic violence, its impact on children, appropriate responses for both victims and batterers, and culturally responsive practice in the area.*

3. *Provide incentives to states to conduct joint training of family support and domestic violence programs. This might include family support training for domestic violence program staff.*

4. *Develop domestic violence intervention tools for family support programs.*

Family support programs are requesting training materials that go beyond a conceptual understanding of domestic violence and provide workers with practical skills to assist a family.

Community Needs Assessment

1. *Ensure that any community needs assessments that are required in relation to family support address gaps in resources to prevent and respond to family violence.*

2. *Offer fiscal incentives to family support, domestic violence, and child welfare programs and others to partner to develop a plan for promoting a violence-free community and one that responds appropriately to child and adult victims and to batterers when violence occurs.*

Policy

1. *Funds to enhance the quality of family support programs should state explicitly that they can be used to prevent family violence and to respond to both adult and child victims of such violence.*

2. *Include explicit language in the reauthorization of Head Start and Early Head Start that supports violence prevention and the establishment of responses to child and adult victims of abuse as part of family support activities.*

3. *Federal guidance to states for the implementation of the Promoting Safe and Stable Families Program should make clear that preventing domestic violence and responding*

to the child and adult victims and to the batterers in situations of domestic violence is an eligible activity in three of the four core activities designated in the program (i.e., family support, family preservation, and time-limited reunification).

4. *Additional resources are needed to support added services for children and families experiencing domestic violence.*

Research

1. *Invest in research to identify and evaluate effective approaches for family support programs to respond to child and adult victims and to batterers, and to identify and evaluate how domestic violence programs might use family support programs as part of the community support and safety system.*
2. *Develop appropriate parenting education and child development curricula and strategies for family support programs working with parents who are victims and with their children.*

About the Author

Nilofer Ahsan, M.P.P., is an Associate at The Center for the Study of Social Policy. She has worked with practitioners and those using services to develop materials and tools to shape policy and program development in children and family services for fifteen years. Nilofer has worked with family support initiatives in over 20 states to improve programmatic practice and develop evaluation and assessment strategies. She is currently involved in a number of new efforts to develop innovative practice models in the following areas: early care and education, domestic violence, child abuse and neglect prevention, and parent and resident leadership.

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Appendix A

Domestic Violence Assessment Questions

Questions to identify if violence is occurring in the relationship

- I'm worried about you. Is everything okay at home?
- Do you ever feel afraid? Do you ever feel afraid at home? What makes you feel afraid?
- I noticed (an injury). How did it happen?
- I noticed you seem jumpy/nervous around your partner—what is it like between the two of you? What happens when your partner gets angry or you have conflicts or differences of opinion?

Questions to ask to understand the dynamics and severity of violence in the relationship

- What is the relationship like when things are good?
- What is the relationship like when things are bad?
- What types of things make your partner angry or mad?
- How often does your partner get violent or angry with you? Have the violent incidents been increasing or decreasing over the past six months? Have they become more severe or scarier?
- Describe the worst time.
- Does your partner use drugs or alcohol? Do you use drugs or alcohol? How does alcohol/drug use affect the violence?
- Have you ever spoken to your partner about the violence? How has he reacted?
- Has anyone else ever spoken to him about it? How has he reacted?
- Have you ever thought of leaving? How do you think your partner would respond?
- Have you ever attempted to leave? How did your partner respond? What made you return?

Questions to ask to understand the impact of the violence on children

- How does your partner treat your children?
- How do your children respond to your partner?
- Has your partner ever injured or threatened your children? If so, how often do these incidents occur?
- Do you think your children are aware of your partner's violence or anger toward you?
- Have your children ever tried to intervene between you and your partner? What happened?
- Do you ever feel that the violence in the relationship makes it hard for you to be a good parent? In what ways?
- Do your children exhibit any signs that the violence may be affecting them?

Appendix B

Addressing Child Abuse and Neglect

Steps to take if you suspect that child abuse or neglect is occurring in conjunction with the domestic violence

- Find out more—try to determine the nature of the abuse or neglect, its frequency, and intensity.
- If the abuser is the domestic violence perpetrator: Talk to the victim, express your concern for her and her children, explore the impact that the abuse is having on her children. Ask about ways she keeps the children safe. If the children are at risk of serious harm, tell her that you are required by law to make a child protective services (CPS) report but that you can help her. Ask if she would prefer to make the report herself with your assistance.
- If the victim of domestic violence is herself the perpetrator of child abuse or neglect: Tell her that you are obligated to make a CPS report. Explore whether the domestic violence is affecting her ability to parent and is hurting her children. Tell her that you will work with her to help her.
- When making a CPS report, be sure to specify the actions that the adult victim has taken to protect her children and what she needs to protect them.
- Try to advocate for the victim with the CPS system. Unnecessary placement of children in foster care can add to the trauma of domestic violence, both for victims and children. At other times, child placement may be critically important to insure safety. Advocacy can include attending meetings with victims, helping them explain their circumstances, and advising CPS workers about safe times and places to conduct interviews and visit the home.

Appendix C

Signs That Young Children Are Being Affected by Exposure to Violence

Emotions

- Worries about being safe
- Feels jumpy and scared
- Nightmares
- Feels unprotected
- Worries about mother or caretaker
- Anxiety, clinging, or crying
- Fearful of exploring on own

Behavior

- Problems with or regressions in development
- Bed wetting
- Fears and increased separation anxiety
- Increased fighting or violent behavior with other children

Thoughts

- Concerns about death, dying, and grieving
- Believes that there is no one to depend on
- Unable to concentrate in school or at home
- Unable to remember
- Easily distracted

—From Joy D. Osofsky, Ph.D., *Keeping Your Children Safe*,
a publication of The Violence Intervention Program for Children and
Families, LSU Medical Center, Department of Psychiatry, September, 1997.

Police in the Lives of Young Children Exposed to Domestic Violence

Series Paper #4

Introduction

Police officers responding to a domestic disturbance call entered an apartment and found a young woman conscious and alert but badly bleeding from a stab wound in the shoulder. As emergency medical personnel treated the victim, officers interviewed the woman, who reported that her estranged husband had stabbed her and fled the home. Using her description, police searched the vicinity and found a blood-stained man hiding in the bushes outside the house. Officers arrested the man and transported him to police headquarters. When they checked the apartment, officers discovered two children (ages 2 and 4) huddled under a bed. Both children appeared uninjured. When officers coaxed them out, the two-year old clung mutely to the officers. The four-year old began to cry.

Police officers respond to cases similar to this one every day. In most communities, officers are not trained to recognize or respond to the distress of the young children they encounter. A common police response might continue as follows:

One of the responding officers checked the victim's status with emergency medical personnel, and, after learning that she would be transported to the hospital by ambulance, called the child protective service hotline to arrange placement for the children. He noted the call to CPS in his report but did not include any additional information about the children's appearance or behavior at the scene. Police follow-up on the case was conducted by a domestic violence detective, who took a formal statement from the victim, obtained photographs and hospital records, interviewed neighbors, and researched the perpetrator's criminal history. Police did not mention to the mother any concerns, or offer any services, for the children.

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In a growing number of other communities, police departments are developing linkages with other community institutions and resources which enable them to respond more effectively to the needs of children and families. For example, in New Haven, Connecticut, where the local police

department, domestic violence agency, and child mental health clinic participate in a collaborative intervention project, the same police call might continue in a different way.

> *After coaxing the children out from under the bed and determining that neither one was injured, an officer knelt down and addressed both children, saying, "Wow, this has been a really scary bad night. How are you guys doing?" When neither child answered, he continued, "Mommy got hurt, but she's going to be okay. The doctor is helping her." While one officer sat with the children, another officer helped the mother identify a sister who lived nearby and could come for the children while she went to the hospital for treatment. Officers then explained to the children that they would be safe with their aunt until their mother could come home. They also informed the mother about the collaborative partnership's emergency service that could provide advocacy and safety planning for her and immediate clinical support to the children. With the mother's permission, an officer called the emergency pager and arranged for a domestic violence advocate and a clinician to speak with the mother by phone immediately and to meet her and the children the next morning at the aunt's house. In addition to investigative follow-up by a detective, one of the responding officers stopped at the family's home several times in the weeks following the assault to check in and make sure they were safe.*

Each year police respond to hundreds of thousands of episodes of domestic violence. Precise nationwide prevalence data cannot be obtained because existing data ordinarily do not report the relationship between victim and offender or the presence of children at the scene. Some states do maintain statistics regarding criminal reports of domestic violence, though each jurisdiction utilizes its own definition of the crimes included. For example, police departments throughout the state of Connecticut reported 20,927 arrests for family violence in 2001, with children present in 43% of the cases (Connecticut Department of Public Safety, 2002). In New Haven, Connecticut, a small urban city of approximately 110,000 people, police investigate an average of 2,000 domestic violence incidents per year. Fifty-five percent of police reports note the presence of children; 20% note the presence of children three years old or younger (New Haven Department of Police Services, Domestic Violence Unit Statistics, 2001, personal communication).

The Spousal Assault Replication Program (SARP), a research study in five cities, developed a database from carefully selected misdemeanor domestic violence cases (Fantuzzo, Boruch, & Beriama, 1997). In all five sites, households with children were disproportionately represented in the sample, as compared to census data for the relevant community, and children under five were more likely than older children to be present in the homes in which domestic violence occurred. Furthermore, children younger than five were more likely than older children to be exposed to multiple incidents over a 6-month period and were more likely to be exposed to parental substance abuse. For example, of the 633 children included in the Charlotte, North Carolina, data, 42% of children under five had experienced multiple incidents of domestic violence, compared to 27% of children aged six to eleven.

Other authors have documented the range of risks that children experience as a consequence of their exposure to domestic violence, including acute disruptions of sleep; problems with attention and other bodily functions; emotional and behavioral difficulties, including both internalizing and externalizing problems; and longer lasting disruptions of school functioning, emotional regulation, and relationships (Carlson, 2000; Edleson, 1999; Fantuzzo, et al., 1991; Graham-Bermann & Levendosky, 1998; Jaffe, Wolfe, & Wilson, 1990; Kolbo, 1996). Retrospective studies also provide evidence that children exposed to domestic violence are at heightened risk for aggressive behavior as adolescents and adults (Thornberry, 1994; Widom, 1989).

Both clinical experience and research demonstrate that individual children respond to domestic violence and other potentially traumatic events based on a complex and inter-related set of factors within the child, the family, and the environment (Carlson, 2000). While adults often tend to predict children's responses based on the details of the event itself, one very important determinant of a child's experience is developmental, including the child's cognitive and emotional capacities for understanding and assimilating the experience and the resonance of the events with specific anxieties common to the child's developmental phase (Marans & Adelman, 1997). (See Appendix A for a summary of the developmental issues.)

Police officers, too, know from experience that the children they encounter at these scenes are often visibly distressed. They appear frightened, sad, or angry. Sometimes they look vacant or numb. Officers are also familiar with the experience of seeing the same children they first met as witnesses to domestic violence later engaged in delinquent behavior or involved in violent incidents themselves, either as victims or as aggressors.

For police officers, domestic violence cases present some of the greatest challenges in their work. Incidents are often repetitive, emotionally charged, and volatile. Scenes can be dangerous for all parties involved, including the responding officers. Yet, because most calls concern misdemeanor offenses, criminal justice remedies tend to be limited, and officers often find themselves stymied in their efforts to provide realistic protection. Officers are also often frustrated when their efforts to assist battered women are met with suspicion, disbelief, or resistance. Even when officers are aware that women may have many good reasons for not calling the police, or not actively pursuing prosecution of their abusers, it is easy for action-oriented officers to feel angry or resentful. In this context, it is not easy for police officers to consistently notice and attend to the children they encounter.

In poor communities and communities of color, it may be especially difficult for battered women to seek or accept help from the police. Current and past experiences of police racism, discrimination, or brutality, as well as negative experiences with other institutional authorities, such as child protection and immigration, create a climate of fear and distrust that deters women from calling the police or from revealing the extent of their abusive experiences (Websdale, 2001). In this context, parents may also make every effort to minimize police officers' contact with their children.

Police officers are in a unique position to intervene in the lives of young children who are exposed to violence in their homes. Though the specific event that prompts a police response is rarely the first incident of violence in the family, officers may be the battered woman's first point of contact with a network of social institutions that may provide greater safety and support for her and her children. The officers' obligation to respond anywhere, at any time, also places them in a position to come into contact with women and children that other service providers may not see. These first encounters present opportunities for police officers to build trust based on respectful interactions with victims, perpetrators, and their children.

This paper is intended to explore the important role that officers can play in assisting young children and their families who experience domestic violence. In focusing on the potential positive role that police officers can play, we do not suggest that the coercive criminal justice system is well equipped to address the needs of children and families affected by violence. In many cases, battered women can obtain far more useful supports from voluntary institutions and informal community networks that do not carry the stigma or the punitive consequences for the family that characterize law enforcement intervention. Where early, non-coercive intervention is available, this may assist in preventing criminal justice intrusion into families that are already vulnerable. Law enforcement is, however, an essential component of an effective community response to domestic violence, and for those situations in which the police are involved, the tone and content of the officer's interactions can have a significant effect on the outcome.

This paper views the daily interactions of police officers with battered women and their children through the lens of child development and clinical experience in order to clarify the potential psychological significance of police to young children and their families. It also seeks to translate young children's experience of officers into language that may connect with officers' own observations. Many of the suggested intervention approaches are based in the practice of community policing (discussed below) and grow out of the authors' experience working in poor urban communities. Many of these strategies and recommendations can be implemented in a broad range of communities and policing settings, provided that officers and their supervisors are open to considering their work through the eyes of children.

Current Police Practice

While there is enormous variation in police practice, depending on the size of the department, local legal requirements, community culture, and law enforcement philosophy, police officers generally focus little attention on children who are not themselves either victims or perpetrators of crime. A uniformed police officer responding to a domestic violence call has a circumscribed role. The officer is expected to arrest an abuser; question, inform, and protect a battered spouse; take a report; and report child maltreatment to another governmental agency if observed and documented. In large, urban settings, where roles are often defined by a complex division of responsibility between agencies or sections of agencies, the adult members of the family may have contact with a diverse array of personnel associated with the criminal justice system, including

detectives, prosecutors, judges, victim-witness specialists, and police-affiliated victim outreach services. Children, however, are likely to remain unnoticed or, if concurrent child maltreatment is documented, to be referred to child protective services. In smaller communities and rural areas, resources may be so limited that there is no one to follow up on the initial police officer's response.

Over the last two decades, the battered women's and victims' rights movements have had a major impact on policing and on the larger criminal justice system. Police have developed an increased awareness of victims' issues. New training programs and special victims' units have been created in response to the effort. It is common for academy recruits to receive training regarding the social and psychological issues associated with domestic violence, and senior officers are often required to attend refresher courses updating them on new developments in this area of the law (see, e.g., Monti-Catania, 1993; New Haven Department of Police Service, Training Academy, 2001; Pence & Paymar, 2001; State of Connecticut, Police Officer Standards and Training Council, 2002). Most large police departments have domestic violence investigative specialists, if not entire units. Many agencies have experimented with different procedures for officers to use when they encounter such crimes. Arrests are often mandatory, and additional paperwork is prepared in order to specifically track these cases.

Training for Police Officers Regarding Children

In New Haven, Connecticut, the Child Development-Community Policing Program provides a seminar for officers and others on child development, human behavior, and policing practice. Twenty hours of training, co-led by police supervisor and mental health clinician, organized in developmental sequence (Marans et al., 1995).

In Boston, Massachusetts, the Child Witness to Violence Project provides a seminar for police on child development, response to violence, and children's views of police. Semester-long course gives college credit (Groves, unpublished curriculum).

The Centre for Children and Families in the Justice System has developed a manual for trainers designed to guide training for officers on children exposed to domestic violence (Baker, Jaffe, Berkowitz, & Berkman, 2002, available on-line at www.lfcc.on.ca/pubs.htm).

A series of training videos for police officers filmed in New Haven, Connecticut, by Family Communications illustrates the range of roles police can assume in interacting with children, youth, and families (Seamans & Seamans, 2003).

Despite these advances, most police departments do not train or expect officers to look for or act on behalf of children as unintended victims or individuals in immediate need. (A trend among some police departments to provide greater attention to children is described in Smith, Nickles, Mulmat, & Davies, 2001). Police training about children's development, behavior, and experience is rare. (See box for police curricula regarding children.)

In large communities, where specific child-oriented services are more likely to exist, officers are commonly trained that other specialized units within the police department, or within other

government agencies, can follow up with children after the fact. The lack of attention paid to children by most police departments is primarily a reflection of a narrowly focused definition of the police role and a compartmentalized mode of organizing and delivering police services. For example, though many police departments have specialized domestic violence and youth services units, those units usually operate separately, with domestic violence detectives focused on violence between adult intimate partners, youth detectives focused on juvenile delinquency and child abuse, and neither unit having regular interaction with neighborhood patrol.

Beginning in the 1980's, the community policing movement has brought dramatic change to many police departments throughout the country, particularly in large, urban settings. This approach to policing provides a philosophical and organizational context for increased police attention to relations with diverse communities as well as to the experience of children and families. Unlike traditional 911-driven policing approaches, which rely on rapid police response by officers who do not necessarily have any previous or continuing relationship with the community in which the event occurred, community policing emphasizes crime prevention and problem-solving efforts, which require officers to become familiar with their neighborhoods and to develop ongoing alliances with community residents, groups, and institutions (Geller, 1991; Goldstein, 1990; Kelling, 1988; Sparrow, Moore, & Kennedy, 1990).

"Community policing" takes many forms in different communities (see, e.g., Cordner, 2001; Office on Community Oriented Policing Services, 2002; Police Executive Research Forum, 1996; Wycoff and Skogan, 1998). Some police departments have established self-contained community policing units, which operate in a limited geographic area or as community service adjuncts to more traditional patrol. Other departments have integrated community policing approaches throughout police operations.[1] Common community policing strategies include long-term assignment of officers to circumscribed neighborhoods and increased use of walking beats, bicycle patrols, community-based substations, and school-based officers, all of which facilitate regular, non-crisis interaction between police and community residents. Many departments have established neighborhood management teams or citizen advisory boards to engage community residents in identifying community concerns and helping to set police priorities. In poor or immigrant communities and communities of color, community policing requires the police to build personal and institutional bridges to historically disadvantaged and distrustful communities (Goldstein, 1990). Strategies include increased recruitment of minority, immigrant, and bilingual officers; increased training for officers regarding specific cultural practices and barriers to interaction with the police; police involvement in community councils; and engagement with community leaders, etc. (e.g., Coventry & Johnson, 2001). Where community policing efforts have been most successful, officers cease to be anonymous representatives of governmental authority and become familiar figures in the community. Along with familiarity, officers often

[1] Much of this paper is based on the authors' experience in New Haven, Connecticut, which has pioneered a model of community policing comprising the entire police department and focusing officers' attention specifically on the experience and needs of children and families (see Marans, 1996).

become trusted brokers of information and resources and develop a greater investment in the well-being of the community they serve.

The adoption of community policing has important implications for police response to domestic violence. In these settings, as in rural areas and small towns, the officers who respond to an acute call are more likely to be familiar to the parties, either from prior calls for domestic disputes or from other neighborhood contacts. Both at a neighborhood level and at a department-wide level, community-based officers are more likely to have established relationships with advocacy and support organizations that can assist in addressing some of the victim's and family's needs. In addition, officers' conception of their role as problem solvers may generate more comprehensive efforts to understand and address the patterns and underlying causes of a violent incident as well as the complexity of the victim's ongoing needs (see, e.g., Anderson & Herman, 2002).

While community policing provides a context for increased police attention to the experience of battered women and their children, including the effects of race, ethnicity, and poverty, it is important to recognize that many departments have never embraced this mode of law enforcement, and that other recent developments in policing have directed attention away from officers' personal contacts with members of the community. Most recently, the events of September 11, 2001, and the subsequent wars in Afghanistan and Iraq have increased police concerns about terrorism and security, directed resources away from services to poor children and families, and heightened the fears of many immigrant communities in dealing with law enforcement and other governmental authorities. In addition, the "compstat" movement of the 1990's has applied computerized techniques to track and analyze daily crime data and has increasingly held police commanders accountable for immediate identification of crime trends, along with rapid and effective responses. This increased emphasis on measuring and documenting the outcomes of police strategy readily coexists with community policing, but it can have the potential to divert attention from outreach and relationship-building activities, which require long-term commitment on the part of officers and produce results that may be difficult to quantify.

Recommendations For Police Practice with Regard to Young Children

Regardless of the policing approach in operation, there are guidelines which officers can follow that promote increased safety, security, and support for children's development. There are additional police interventions that may be possible in a community-based police setting, where there is an emphasis on problem solving, establishment of relationships between police and community members, and respect for cultural diversity. The scope of police interaction with children will necessarily depend on the specific organization of the department and on other resources present in the community. A guiding framework for police action falls into the following categories:

- supporting parents' efforts to keep their children safe,

- recognizing children's physical and psychological dependence on parents,
- building officers' awareness of how victims and witnesses experience violence and trauma,
- interacting with adults and children in a respectful and non-punitive way, and
- establishing institutional connections between police departments and other community and cultural resources that support battered women and their children.

Using this framework, the following sections delineate a range of police interventions that can benefit young children exposed to domestic violence.

Importance of Restoring Order and Establishing Safety

The first and most central police intervention is to reestablish immediate order and safety—to stop any ongoing violence; to obtain medical care for the injured; to identify, locate, and contain aggressors; and to restore calm to the household. The officer's attitude and approach to victims, witnesses, and offenders will have an enormous effect on the way in which all parties experience the police and, consequently, on the effectiveness of the intervention. Violence interrupts children's experience of consistent safety and care, and creates an environment marked by danger, overwhelming stimulation, and helplessness. The repetitive and persistent experience of helplessness can lead to disruptions of children's development, in both the short and long term. When police officers are quick to restore safety, and when they do so in a calm, respectful, culturally sensitive and non-punitive manner, they set the stage for battered women and their children to reestablish their own sense of security and control.

Thorough Investigation and Documentation To Increase Safety

Officers should carefully document the event, including witness statements and physical evidence. Good investigation leads to the widest possible array of options for using the criminal justice process. Criminal sanctions can be an important part of a plan to increase safety for the family. In addition, careful attention to the investigative aspects of the case sends a message that police take the incident seriously, that it is not "just a domestic."

In many cases, police will not need to conduct direct interviews with young children, because the officers have adequate physical evidence and adult statements. When children's statements are not needed, officers should refrain from interviewing them. Young children communicate in a different way from adults and older children, which may require special interviewing techniques. They may find the experience of being interviewed difficult and anxiety provoking, especially if they are being asked to give information about bad behavior of parents whom they love, or if they feel they are being asked to choose sides in an ongoing family battle. These conflicts may be especially salient for children (often racial minorities or recent immigrants) who are aware that their parents do not trust the police and would like them to have as little contact as possible with officers. When children are essential witnesses, officers should seek consultation from child development professionals or specialized detectives in order that interviews can be conducted in

language appropriate to the child's development, in settings as supportive as possible for the child, and recorded so that they do not need to be repeated.

General Awareness of Children at the Scene

Officers know from experience that young children are frequently present at scenes of domestic violence. They should not assume that children are sleeping (even if it is nighttime) or that young children do not notice or understand what has happened. Even very young children can be acutely aware of changes in their parents' tones of voice and can have frightening ideas about what can happen to their parents or to themselves when caretaking adults become violent.

Officers should document the presence of children at scenes of domestic violence, their roles in relation to the event, and their observable reactions. There are several purposes for paying attention:

- to ensure that children are not physically injured;
- to document evidence of crime involving risk of injury to children;
- to determine if children are essential witnesses to a crime (e.g., when adults are so badly injured that they cannot report what happened);
- to determine if a report to child protective services is required; and
- to establish a basis for facilitating access to appropriate services and for talking with parents about their children's responses to the violent incident, and concerns about the children's safety.

In collecting information about children present at scenes of domestic violence, officers should be clear about what purpose they are serving; and they should be prepared to explain to parents why they are asking about children who were not physically injured or directly at risk. Without such explanations, parents may experience the police inquiry as intrusive and critical, or as a prelude to a punitive action by child protective services (CPS), particularly if they are already wary of the police based on culture, prior experience, or other factors. When officers are clear about the reasons for their inquiries, it is easier to avoid unnecessary intrusion into the lives of children and families. For example, when there are services to which police officers can refer battered women for information and assistance about their children, identification of children can lead to greater support for vulnerable victims and witnesses. Similarly, a community-based officer who regularly patrols a particular neighborhood may ask about children as part of an effort to let the woman know that police are interested in the family's safety and well-being, and that this officer can watch out for them as he patrols the neighborhood.

Recognition of Children's Need for Continuity of Care

Usually the best way to provide safety and security for a child is to assist the child's non-offending parent to make the child safe. In the immediate aftermath of violence, most young children will look to their parent or to another very familiar adult for comfort and reassurance. When a parent

is uninjured, but is very upset and having difficulty paying attention to her children, officers can help the parent to calm down and can quietly remind her that her children need her even more at such an upsetting moment. Officers can take time to talk with the mother about what she thinks she needs in order to stay safe, and can direct her to available resources in the community. When a mother is either seriously injured or so emotionally distraught that she cannot look after her children at the scene, officers can help her to identify and find a relative or close friend whom the children know and trust. In general, police officers will be more helpful to children if they see themselves as assisting parents to exercise parental responsibility rather than as providing safety for children independent of their parents.

Whenever possible, officers should avoid separation of young children from their primary caregivers. The experience of separation is often more distressing to a child than the precipitating violent event. In cases where there is evidence that both parents were involved in aggressive behavior, it may be possible to use a written summons rather than a custodial arrest for the less aggressive parent and to leave that person home to care for the children. Where a dual arrest is mandated, officers should attempt to leave the children with a familiar person rather than with a stranger. Where state law requires a CPS report and places the decision about temporary child care in the hands of the child protection worker, police may still be able to assist the parents to identify a familiar adult (e.g., a grandmother) who can come immediately to the scene and assume temporary responsibility.

Awareness of Children's Responses to Violence and Trauma

Children may have many conflicting feelings about care-giving adults who hurt each other and about the police who respond. Children may be angry that the police arrest their father, even though his behavior was scary. Children may be scared by the officers' assertion of power and control over an aggressive parent, particularly if the parent resists. Children may be saddened by the loss of a parent or parent figure even though the individual may be a less than ideal parent. For children who have repeatedly seen or heard about friends and family members being arrested and incarcerated, police action may arouse a host of negative memories and associated feelings. If possible, police should not handcuff or otherwise subdue a parent in front of a child. Whenever possible, police should also avoid conducting investigative interviews with parents in the presence of children.

Police will necessarily record observations of physical injury. Police at the scene are first responders and can be good observers of the markers of psychological impact, such as crying, withdrawal, clinging to a parent, lack of any visible response when one is expected, emotionless recitation of facts, or agitated or aggressive behavior. Documentation of these reactions may assist investigation of some crimes, such as risk of injury to a minor. Greater awareness of children's distress may assist officers in talking with parents about the impact of the events on their children, and in making effective referrals to other services.

With very young children (under two years of age), officers should usually not attempt to discuss the incident directly but should focus on making sure the child is safe and in the care of a trusted adult who can provide appropriate explanation and reassurance. For slightly older children, officers should explain, in simple terms, the outcome of the call (for example, "We are taking your father with us to the police station, and your mother is going to be checked out at the hospital. She is going to be okay and she will be home in the morning. Your grandmother is here and will stay with you until Mommy gets home."). They should offer children the opportunity to ask questions and should answer as honestly as possible (for example, in response to questions about where the father is going and when he will be back, "We are taking your Daddy with us to the police station. We need to make sure that everyone stays safe. The judge will decide when it is safe for him to come home.").

Directly addressing the child sends the message that officers are interested in the child's experience and care enough to listen. Listening with an open mind allows officers to know the child's concerns (which may be quite different from those of the adults) and to respond appropriately. For example, some children worry that a parent who is arrested will be cold or hungry or hurt in jail, or imagine that there was something the child could have done to stop the violence. If officers are able to hear these ideas, they can provide facts that address the issues on the child's mind.

Recognizing that children are usually most comfortable in the presence of familiar adults, and that many adults will be anxious about what the police may ask or tell their children, these conversations should ordinarily take place with parents and children together. Officers should not tell the child that they will be better off without the arrestee, because such statements ignore the complexity of the child's feelings and relationships. Officers should emphasize that the adult (usually the mother) who is left to care for the children will be in charge of keeping the children safe and that police will help if needed.

Officers' awareness and documentation of the impact that violence has on adults is also important. For example, familiarity with the general dynamics of domestic violence and the phenomena associated with psychological trauma can assist in establishing rapport with witnesses and victims, more effective interviewing, collection of all available evidence, and the pursuit of appropriate criminal charges. Greater awareness of adult victims' experience can also assist officers in determining appropriate referrals to other agencies that provide safety and support, such as domestic violence projects, emergency shelters, culturally-based community agencies, parent support or mental health programs, and crisis housing and financial assistance initiatives.

Officers' observations related to the psychological impact of violence on battered women and their children should be used for the purpose of informing their work as police and not to substitute for the assessments or interventions by other professionals, such as physicians, mental health professionals, or child protection workers. Officers who understand some of the basic issues related to psychological response to trauma can more effectively use their observations to stabilize scenes of crisis, investigate criminal activity, and develop trusting relationships in the community.

By virtue of their role as first responders to crises, police officers are in a unique position to make observations and convey their immediate impressions to others who have the training, time, and resources to address psychological issues.

Support for Parents in Their Efforts To Provide Safety for Themselves and Their Children

Responding police officers should support the child's caregiver to begin evaluating and planning for her safety. In the immediate aftermath of a violent incident, officers should inform the victim, to the best of their ability, of the status of the offender (e.g., arrested or not, held on bond or released), the likely course of the criminal justice process (e.g., will appear in court next day, may post bond at any time), and the available options to increase the victim's immediate safety (e.g., availability of emergency shelter, jail regulations requiring victim notification prior to release on bond). If emergency advocacy and social service support are available in the community (e.g., domestic violence hotline, home visiting advocates, emergency housing, food, transportation), officers should provide the victim with contact information or, with permission, contact the service directly.

In providing safety-related information, officers should accept the fact that many battered women will choose, for a variety of reasons, to maintain intimate relationships with men who have abused them. It is not necessarily safer or more beneficial for a family to separate in response to an episode of violence. Information about court processes and community and culturally-specific resources is essential to enable women to make the best decisions they can for themselves and for their families based on a realistic appraisal of their options. Information is most likely to be helpful when it is provided in a non-judgmental way, as an aid to the woman's decision-making.

Police officers' knowledge of the criminal justice process, and their contacts with other professionals within the judicial system, can be extremely valuable in addressing victims' immediate safety concerns. For example, officers may be able to affect bond setting decisions or prosecutorial investment in a case by virtue of the details they provide to the court or the effort they make to let judicial officials know they are especially concerned for a family's safety. Immediate pretrial detention may give a victim a window of opportunity to make longer-term plans for herself and her children. Depending on a police department's size and organization, direct contact with court officials may be the function of a centralized domestic violence unit rather than neighborhood patrol. What is important is that the patrol officers consider ongoing safety issues and communicate their observations to officials with decision-making authority.

Different communities will have different advocacy and social service resources available. The extent of officers' role in safety planning will necessarily depend on what other resources exist and how quickly they can be mobilized. Ideally, police officers should have established links with trained and knowledgeable battered women's advocates, and with representatives of minority and non-English speaking communities, who will work with victims to explore options for safety in the short and long term. Where such services exist, first-responding police officers act as brokers of resources and not as all-purpose service providers. In communities where resources are more

limited, officers should assist women to access what does exist (e.g., state-wide hotline, informal advocacy network, helpful clergy), and police leadership should support the efforts of others to establish more extensive resources within the community.

Coordination with Child Protective Services

In all jurisdictions, police are mandated reporters of child abuse and neglect. Because current standards for child abuse reporting vary by state, officers must be knowledgeable about the laws applicable in their jurisdiction and able to explain to parents what and why they are reporting. Officers should include in any report to CPS observations regarding the behavior of children and parents at the scene and other relevant information (e.g., criminal history) in order to inform the CPS determination of the nature and level of risk to the child. Especially in jurisdictions with expansive reporting standards, police officers who are mandated to report child witnesses of domestic violence should include not only observations of risk, but also facts that indicate parents are protective and attentive to their children. Whenever possible, consistent with child safety, officers should also ask battered women when and where it would be safest for CPS to interview them, in order that the mandated CPS investigation has the least chance of further endangering the victim.

There are several important considerations for police when making referrals or working with CPS.

First, officers should be aware that many women are deeply suspicious of CPS and are fearful that they will be held accountable for violence perpetrated by others and will lose custody of their children. Whether or not this is a realistic fear in a particular jurisdiction, the concern is widespread, particularly in poor and minority communities, whose children are over-represented in the child protection system, and in families in which additional issues are also affecting children's care, such as parental substance abuse or mental illness. Officers' status as mandated reporters complicates their task in building trust in the community. The more officers know about the reality of likely CPS action, and the more they are able to talk openly with members of the community about their concerns, the easier it will be for officers to do their work.

Second, officers should be aware that CPS involvement with a family does not automatically lead to removal of children from their parents. In some jurisdictions, CPS may provide access to resources that are not available elsewhere and that can increase safety for women and children, such as priorities for housing subsidies or specialized home-based advocacy and clinical services. In these situations, collaboration between CPS and law enforcement enhances the effectiveness of each (see section on Coordination and Collaboration below).

Third, there are situations in which the criminal justice system can reduce the risk of ongoing violence to battered women and children, and police may therefore be in a position to assist women in avoiding negative child protection consequences. For example, swift police action leading to immediate incarceration of a serious offender can sometimes relieve a victim of the forced choice between disruptive temporary shelter and placement of her children.

Domestic violence is often repetitive. It can be extremely frustrating for officers to respond again and again to the same household without seeing any benefit from their efforts. It can be tempting for officers to express their frustration in threats to a woman that if she does not do something to stop the violence, the police will call CPS, and CPS will take the children away. It is essential for police officers to resist this temptation. Reports of child abuse and neglect should be based on established criteria for risk. Threatening CPS action is likely to deter women from calling the police or from fully disclosing the nature and extent of the violence against them.

Follow-Up Police Contact: A Relationship-Based Approach

In many community-based police settings, officers who respond to domestic violence calls are likely to have had previous contact with the victim or perpetrator. Officers who are regularly assigned to neighborhoods are also likely to have opportunities for additional contact that can reinforce and expand the officer's role in maintaining security and brokering resources. Follow-up contacts can be informal, in the course of the officer's regular presence in the neighborhood. In New Haven, Connecticut, an earlier Child Development-Community Policing (CDCP) project, a police/mental health partnership (Appendix B), formed a basis for a new Child Development-Community Policing Domestic Violence Intervention Project (CDCP DV), and under this latter project there is a regularly structured follow-up protocol (see Appendix C). Voluntary follow-up visits can serve the purposes of monitoring safety, enforcing court orders, building relationships with victims that can facilitate future reports if additional violence occurs, and establishing a context to provide information and referrals to other social services, including support and therapeutic programs for children.

In building a relationship with a battered woman, officers might focus on the woman's concern for her children. Sometimes it is easier for a mother to think about the vulnerability of her young children than her own vulnerability. For some women, their sense of themselves as competent mothers can survive as a source of strength and pride even when they feel frightened and hopeless about other aspects of their lives. Officers who notice young children and comment on a mother's care for them can demonstrate their own interest in the safety and security of the family.

Sometimes children's distress does not appear until several days or weeks following a traumatic event, and so a follow-up visit may present a more effective time to make a referral for child-oriented services. Officers must be careful to avoid expressing their concern in a manner that criticizes or threatens the mother. (For example, "You have been through so much recently. You must be so concerned about what your kids make of all this," sends a very different message from "I can't believe you keep letting those kids see him beat you up. That's really going to mess them up.")

In pursuing follow-up contacts with victims of domestic violence, officers should also be aware that there are many reasons why some women will not want to establish ongoing contact with the police. They must be prepared to respect these women's desire to be left alone, unless there is further evidence of crime justifying police involvement.

Active Interdisciplinary Coordination and Collaboration

Law enforcement is only one piece of an effective response to domestic violence. Factors relevant to the safety of battered women and their children can be clustered in three domains: physical safety, environmental needs, and psychological response. Interventions will usually be most effective when the responses of several institutions are coordinated and when a comprehensive approach addresses all three of these domains simultaneously. Many factors may be involved in a single case. For example, a woman may not call the police to report a beating by her partner because she fears that the police or the court will not take her seriously, that her partner will retaliate against her, that calling attention to herself and her partner will lead to the deportation of one or both of them, or that she cannot support her children financially if he leaves the household. A woman's difficulties in one domain often affect her willingness to make use of assistance offered in another. In this respect, low-income women are especially vulnerable because poverty imposes so many limitations on their ability to change aspects of their environment—such as housing, employment, or child care—and because economic deprivation already places so many burdens on their ability to provide for their children. While police departments cannot provide direct economic resources for victims, police intervention on behalf of low-income women will be more effective if it is coordinated with advocacy for financial support.

Similarly, a woman's psychological response to violence against her can have serious negative consequences for her capacity to seek safety or to engage with social service providers. In some cases, victims of traumatic violence may have limited ability to provide the coherent narratives and specific factual details that are required for legal action. Basic psychological support can be essential to facilitate cooperation with law enforcement and active engagement in other safety-seeking activities.

Police may initially find this way of thinking about domestic violence too complex or too distant from their central mission of law enforcement to be useful. They may worry about additional demands on their time if they begin to consider issues beyond legal response to crime. However, a broader view of the problem does not necessarily lead to increased personal responsibility for individual officers, but instead leads to alliances with other potential helpers. Effective interdisciplinary partnerships rely on each member to remain clear about his role within the team.

As part of a coordinated and diversified network of intervening agencies, the central activities of the police are (a) first response to crises, (b) collection of evidence, (c) problem solving related to specific physical safety issues (e.g., timely warrant service, enforcement of court orders, follow-up police presence), (d) active coordination of information flow with other criminal justice agencies, and (e) referral to social service providers. With appropriate permission from the victim, these police activities should be coordinated with the efforts of professionals who are addressing problems other than the legal ones.

Police departments should develop linkages with a wide range of social service institutions in their communities—including domestic violence shelters and advocacy groups, culturally specific

agencies, family service agencies, child and adult mental health agencies, child protective services, religious organizations, and other community groups. Where community-wide coalitions against domestic violence exist, police departments should participate actively. (See box for sample police collaborative programs and see Appendixes B and C for descriptions of the initial and the expanded Child Development-Community Policing Program, a model collaboration among police, battered women's advocates and child mental health professionals.)

Multi-disciplinary partnerships often develop most successfully when smaller and more personal collaborations are established first, and additional partners are added to a functioning core team. In some communities, not every partner needs to have a close connection with every other partner, as long as participants in the overall collaboration know where to look for specific resources and know which of their core partners has the best links to those resources. It may be most useful for police departments to identify a few agencies that provide essential services to battered women and their children and to build close relationships with them.

Police Participation in Interdisciplinary Collaborative Partnerships

The Child Development-Community Policing Program is a model collaboration among police, child mental health professionals, advocates, child protection professionals, and others. It was developed in New Haven, Connecticut, and is active in 13 other communities (see Appendixes B and C).

In Cuyahoga County, Ohio, the Children Who Witness Violence Program involves five urban police departments in an emergency referral and response project for children exposed to violence. Police receive training and make referrals to mental health professionals. The team also conducts public awareness activities (Smith et al., 2001).

The Domestic Violence Enhanced Response Team (DVERT) in Colorado Springs, Colorado, involves police, probation, child protection, women's and children's advocates, animal shelter, and other supportive agencies in a coordinated response team for serious domestic violence cases. Home-based assessments and follow-up services are provided to battered women and their families. (See www.dvert.org)

In Vermont, a state-wide committee convened by the Coalition Against Domestic Violence engaged battered women's advocates, police, prosecutors, child protection, and a variety of individuals and community agencies in a process of developing a recommended protocol for police response to children exposed to domestic violence (R. Pulliam, personal communication, September 11, 2003).

In San Diego, California, police participate with prosecutors, women's and children's advocates, and child protection and family court personnel in a co-located service center for domestic violence victims and their families.

Recommendations for Police Policy with Regard to Young Children

1. Police Leadership

Day-to-day police practice is dependent on leadership, consistent supervision, and institutional rewards. Therefore, police leadership must set a tone that children are important,

and that it is part of the mission of the department and the responsibility of every officer to attend to the experience of children exposed to domestic violence and their families.

Police leadership must support and enforce specific protocol changes, allocate resources to training and supervision of officers in activities related to their response to children, and maintain relationships with social service agencies and members of the community.

2. Police Protocols

Police departments should examine existing protocols for responding to domestic violence calls and should institute specific requirements that officers note, describe, and respond appropriately to children present. (See Appendix D for areas of police practice in which specific protocols can be developed for response to domestic violence involving children.)

3. Police Training and Supervision

Training about children exposed to domestic violence should be mandated for certification of officers at all levels—i.e., academy training for recruits, in-service education for veteran officers and new supervisors.

Mandated training should include:

a. basic orientation to the dynamics of domestic violence;

b. an overview of expectable immediate and long-term psychological responses to trauma and victimization for adults and children;

c. the importance to children of continuous care by a primary care-giving adult;

d. information related to existing resources in the community to assist battered women and their children, and procedures for making referrals; and

e. details of mandatory police protocols in response to domestic violence and children's exposure (e.g., reporting requirements, mandatory referrals, standards for CPS reporting, and use of on-call services).

In order for training to be most effective, information regarding the social context of violence against women, child development, human behavior, and response to trauma should be placed in the context of the officer's daily work responding to calls and should be presented in a way that makes clear the relevance of this information to officers in their police role.

Direct supervision is central to properly addressing the needs of victims and children. Supervisors need to reinforce departmental rules related to victims and witnesses—for example, by reviewing all reports to monitor inclusion of information about children. Instituting concrete organizational changes can be helpful, such as including a specific check box on police reports or distributing palm cards with reminders of social service collaborations and criteria for referral. In those departments where officers are expected to make follow-up contacts with domestic violence victims, supervisors must clearly support officers' allocation of time to conduct the expected visits.

Police supervisors also must carefully monitor and reinforce officers' compliance with new protocols and set an example by their own behavior when they handle domestic violence calls.

4. **Funding**

   Increased awareness of children's experience and needs does not in itself require any additional funding. Most of the suggested protocols relate to ways in which police officers perform their existing duties and should not require much more time from busy officers. Funds may be needed to support additional time devoted to police training. Funds are also likely to be needed to support partnerships with advocacy and social service agencies, which will assist officers in maintaining their awareness and attention to children.

5. **Interdisciplinary Collaboration**

   Policing should be seen as one important piece of a community's response to domestic violence and to the experience of young children who are exposed. Police responses should be coordinated with the responses of other social institutions, including domestic violence advocacy, child protection, mental health, education, religious, and other agencies. Building effective partnerships among diverse professional and community groups requires time and resources. Therefore, governmental and private funders should increase the resources available to build and maintain interdisciplinary collaborations.

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Appendix A

Children's Responses to Violence in a Developmental Context

Infants (0-18 months)

Expected development

- Establishing the basis for secure attachment with caregiver
- Dependent on caregiver for protection and nurturance
- Sense of safety determined by consistency of caregivers
- Limited capacity for coping with environmental stress

Common responses to exposure to violence

- Disturbances of sleeping and eating
- Difficulty in being soothed
- Irritability and constant crying

Toddlers (18-36 months)

Expected development

- Look to caregivers for cues, and seek company of trusted adults when anxious
- Increased capacities—physical, cognitive, language, emotional
- Normal struggles for power and control (terrible two's)

Common responses to exposure to violence

- Disruption of expectation that caregivers will protect (e.g., attachment problems)
- Disruptions of eating and sleeping
- Overly active and agitated, or overly passive behavior
- Developmental regression (e.g., loss of language, toileting)
- Intensified struggles for control

Preschool Children (4-6 years)

Expected development

- Use of play to express ideas and feelings
- Increased cognitive, language, and physical capacities
- Increased ability to differentiate reality from fantasy
- Involvement in triadic relationships

Common responses to exposure to violence

- Developmental regression (e.g., loss of language and/or toileting, difficulties in separation)
- Sleep disturbances, nightmares
- General fearfulness
- Temper tantrums
- Loyalty conflicts, conflicts over identification

Appendix A, continued

Children's Responses to Violence in a Developmental Context

School Age Children (6-12 years)

Expected development

- Less reliance on cues from caregivers, more independent
- Increased capacities—language, cognitive, physical
- Increased awareness of self and environment
- Energy directed to school activities, sports and games, healthy competition
- Increased interaction with peers and adults outside the family

Common responses to exposure to violence

- School difficulties—inability to concentrate, poor performance
- Lying, stealing
- Fighting
- Clinging, separation difficulties
- Disturbances of sleeping and eating
- False bravado

Adolescents (13-18 years)

Expected development

- Preoccupied with bodily changes
- Increased sexual and aggressive urges
- Struggles for independence from parents
- Development of identity
- Influenced by peer pressure
- Reemergence of previous developmental issues

Common responses to exposure to violence

- Exaggerated preoccupation with the body
- Acting out—unsafe sex, drugs and alcohol, running away
- Difficulties in relationships with parents
- Avoidance of adolescent development—act as younger children
- Identity confusion
- Feelings of inadequacy
- Involvement in dating violence as victim or aggressor

Source: Marans, S., & Adelman, A. (1997). Experiencing violence in a developmental context. In J. Osofsky (Ed.), *Children in a violent society* (pp. 202-222). New York: Guilford Press.

Appendix B

Child Development-Community Policing (CDCP) Program
New Haven, Connecticut

General:

CDCP is a partnership among community police, child mental health clinicians, battered women's advocates, and others aimed at ameliorating the impact of children's exposure to violence.

History:

Begun in 1991 in response to increase in community violence and at time of New Haven's adoption of community policing philosophy.

Program Elements:

- Training for police, advocates, and others in principles of child development and human behavior as applied to the daily work of policing and other community intervention with families and children.
- Training for clinicians and others in principles and practice of policing, including ride-along observations.
- 24-hour consultation service, which provides guidance for officers in the field and acute clinical response to children and families affected by violence.
- Weekly case conference for review of cases, for planning, and for monitoring of collaborative intervention strategies.

Impact:

- Police now refer average of 10 cases per week; one third of the calls are for domestic violence—increased immediate access to service for children at high risk of post-traumatic symptoms and other developmental difficulties.
- Entire police force has received CDCP training.
- Police have interdisciplinary resources available to assist them in dealing with children affected by violence and are more able to sustain attention to children and families.
- Clinicians are more familiar with acute realities of violent events and immediate responses of adults and children.
- Clinicians are more aware of potential uses of authority in therapeutic work with children and families and are more able to coordinate with law enforcement and judiciary.
- Interdisciplinary team has developed close working relationships that allow for open exchange of ideas and collaborative work on individual cases.

Sources: (Marans, et al., 1995; Marans, Berkowitz, & Cohen 1998; Marans & Cohen 1993.)

Appendix C

Child Development-Community Policing Domestic Violence Intervention Project (CDCP DV)
New Haven, Connecticut

General:

Expands CDCP response to battered women and their children in order to provide better access to services and a broader range of intervention to meet the specific needs of these families.

History:

Begun in 1997 with support from U.S. Department of Justice, Violence Against Women Office.

Program Elements:

- Closer connection with court-based and community-based battered women's advocates facilitates access to a wide range of services.
- Closer coordination with and monitoring of court action following arrest, in order to increase safety.
- Increased involvement of neighborhood patrol officers in monitoring victims' safety and brokering supportive services.
- More active outreach to battered women, using women's concern for their children's well-being as a way to engage them in thinking about safety for themselves and their children.
- Short-term and extended support and therapeutic services available for women and children on a voluntary basis; clinical services informed by and coordinated with law enforcement and advocacy as needed.

Home Visit Outreach:

- Pilot project in 4 of 10 policing districts pairs neighborhood patrol officers and outreach advocates to conduct regular follow-up home visits to households that have reported a domestic violence incident to the police.
- Visits address issues of safety, provide additional opportunity to offer social services in non-crisis atmosphere, demonstrate commitment and interest of police to address domestic violence, and build personal relationships with officers that may facilitate reporting of future incidents.
- Pilot program evaluation data show a decrease of more than 50% in repeat calls to police for domestic violence calls among home-visit cases, as compared to similar cases in non-target policing districts.
- Telephone survey of victims who received visits showed 80-90% general satisfaction, felt safer after the visit, and more likely to call police if new incident occurred.

Appendix D

Areas of Police Practice for Development of Specific Protocols Regarding Domestic Violence Involving Children

1. Police officers responding to a domestic violence call should be required to inquire about the presence of children and, for each child, should record identifying information, role in relation to the event, relationship to victim and aggressor, and observations of the child's behavior at the scene.

2. Whenever possible, officers should avoid conducting investigative interviews of a child's parents in the presence of the child.

3. Whenever possible, officers should avoid subduing an aggressive parent in the child's presence.

4. Police report forms should include a check box to note the presence of children at the scene.

5. Whenever possible, police officers should avoid separating a child from his/her primary caregiver. Therefore, officers should exercise their discretion, in dual arrest situations, to charge one party by summons rather than make custodial arrests of both.

6. When proper disposition of a domestic violence call requires both of the child's parents to be removed from the home (either to detention or to hospital) officers should attempt to leave the child with a responsible adult who is well known to the child.

7. Prior to leaving the scene of a domestic disturbance, officers should provide basic information to a child's caregiver about the disposition of the call and relevant information related to immediate safety. For children over four years old, officers should offer the child an opportunity to ask questions about the event and the police response, and they should answer the child in simple terms.

8. When supportive services are available in the community for battered women and their children, officers should be required to provide mothers with information about existing services and offer to assist in contacting the service.

Working with Young Children and Their Families: Recommendations for Domestic Violence Agencies and Batterer Intervention Programs

Series Paper #5

Introduction

The battered women's movement began with a strong insistence on the woman's right to safety and freedom from violence and threats. As this movement opened shelters and other services, it maintained a commitment to a practice of empowerment by restoring control, dignity, and choice to the women who used its services. From the beginning it has been a central tenet of shelters that battered women are to keep decision making about their lives in their own hands.

It was soon obvious, however, that half of all shelter residents were children. Some of these children came to programs having witnessed terrifying assaults against their mothers. Many of them were very young. What was the best way to help them within a shelter setting while continuing to respect their mother's autonomy? Still other children—fewer in number—arrived neglected or abused, sometimes by the batterer of their mother and less frequently by their mother herself. In still other circumstances, women returned home to their partners, and shelter staff worried about the possible danger that the women and their children faced. What was the role of the domestic violence program in these sets of circumstances?

As domestic violence programs explore these complicated realities, they face the question, "How does the program offer support and safety to children and maintain the basic principles of safety, autonomy, and choice for the battered woman? What is the proper, respectful spirit in which to approach mothers about the needs of their children?" In Part I of this paper, Gewirtz discusses these two questions—the approach to mothers and the content of programming for young children.

Equally difficult dilemmas confront programs for men who batter, as these services accept and integrate the reality that many of their clients are fathers. The principal goal for many batterer intervention projects is to promote safety for women. To this end, programs for batterers work toward holding men accountable, monitoring their violent and threatening behavior, and working closely with the police and courts to try to ensure victim safety.

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Minneapolis, MN

Effective batterer intervention programs are well aware of the danger some men pose as they try to gain unsupervised visits and custody of their children. These programs work closely with women who face extreme danger and want to avoid any future contact with the person who harmed them and their children. However, batterer intervention programs also talk to women who want their partners to have ongoing contact with their children. Some battered women may not consider the violence their most pressing problem and may want to remain in their relationships—and may look to these programs for help to make things better for their families. Batterer intervention programs also know that many men will have ongoing contact with children, sometimes within multiple families.

These issues raise many questions for programs serving men who batter: What is their role for fathers who seek their services? What content about the impact of violence on children and fathering should be integrated into the sometimes brief interventions with men who batter? How can programs avoid, on the one hand, the potentially manipulative use of this content in ways that might hurt women and children, and, on the other, help fathers and families that sincerely want to stay together and improve upon the ways in which they raise their children together. A discussion of the issues related to programs for men who batter—commonly known as batterer intervention programs—is found in Part II of this paper, authored by Menakem.

Part I.
Programs Serving Adult Victims of Domestic Violence and Their Children

Overview

In 1999, over 2,000 programs existed nationwide serving battered women and their families (National Coalition Against Domestic Violence, 2000). Most of these were shelter-based, and a small minority offered services to batterers also. No existing comprehensive source of national data reveals types of services provided or individuals served by community domestic violence agencies. Programs for adult domestic abuse victims vary widely; they may include safe homes, shelters, transitional living programs, legal advocacy, support groups, faith-based programs, and counseling and psychotherapy services. In larger urban areas, culturally-specific domestic violence programs may exist, including culturally-specific shelter programs. Within shelters there exists a similarly wide variety of assistance, from basic shelter and food to support groups, counseling, jobs and education referrals, and health and legal services. Whether, and to what degree, services for children are available is highly dependent on the size and resources of the agency, the priorities attached to working with children, and the existence of funding at state and local levels.

National statistics indicate that between 3.3 and 10 million children witness family violence each year (Gallup, Moor, & Schussel, 1997; Straus, 1992; U.S. Department of Justice, 1998). Although exposure to domestic violence constitutes a risk factor for negative developmental and behavioral outcomes in children of all ages, young children are particularly vulnerable: they are almost totally dependent on their caregivers for the daily necessities of life and require more

physical care than their older siblings, their escape repertoire in instances of violence is narrower than that of older children, and opportunities to spend time outside the home (e.g., in daycare, Early Head Start) are limited.

Women living in households with incomes below the poverty line are disproportionately represented among reported victims of domestic violence—for example, estimates from the National Crime Victimization survey indicate that women in the lowest income brackets are 7 times more likely to be victims of domestic abuse than those with the highest annual household income (Rennison & Welchans, 2000). Not surprisingly, they are also disproportionately represented among occupants of battered women's shelters. While there may be racial differences among women seeking shelter (e.g., disproportionately higher numbers of women of color), when controlling for poverty, racial differences are diminished (Tjaden & Thoennes, 2000). In addition, rates of domestic abuse tend to be highest for women in the 20-24 age group—an age when many women are having children (Rennison & Welchans, 2000). Indeed, on average, children seem to equal or even outnumber women in battered women's shelters. Young children, in particular, seem to be disproportionately represented. For example, in the Harriet Tubman Women's Shelter in Minnesota, 60% of the families with children included children under 6, with these young children accounting for 54% of the total number of children sheltered in 2001 (Tubman Family Alliance, 2002).

For low-income families with young children who may already be at high-risk for developmentally poor outcomes by virtue of their economic circumstances, seeking shelter for domestic violence may be their first effort at seeking help for any of the stressors in their lives. This offers agencies a critical opportunity to both intervene and prevent harm—to offer services to children that promote resilience, and to reduce the chances of future violence (National Advisory Council on Violence Against Women, 2001; Widom & Maxfield, 2001).

The following sections of this paper lay out an approach to working with battered mothers and their children that is predicated upon two basic assumptions. The first assumption is that the needs of mothers often overlap with those of their children, and thus advocating for mothers also means accessing resources and advocating for their children (e.g., school registration, health insurance, medical care when needed). The second assumption is that a basic understanding of children's development (and taking a developmental perspective) is critical to advocating for children and mothers. Taking a developmental perspective simply means understanding how a child's needs and behaviors vary according to the age and developmental stage of the child. For example, while a 9-year-old's tantrums and screaming fits are not appropriate, and should be of concern, these behaviors are perfectly appropriate for a 2-year-old (occurring as they do within a developmental context of increasing independence and the related struggles of the toddler). Taking a developmental perspective also has the benefit of enabling advocates to empathize with the pressures of parenting young children, particularly under the extremely stressful circumstances of shelter residence.

While this approach does not require much extra in the way of training, it does involve asking about what children need and what mothers need for their children. Though many advocates already do this, this may not necessarily be foremost on the minds of advocates who see women in contexts where children may not be present (e.g., legal advocates, women's support groups). In addition to asking about children and children's needs in the context of, for example, legal advocacy, offering basic resources for parents—such as a brief handout that offers guidelines for understanding children's behavior in stressful circumstances, age-appropriate behaviors, and when to seek help—can be informative for both mothers and advocates.

Resources for Children Within Local Domestic Violence Agencies

Despite the historically few funding resources available to domestic violence agencies for child-specific services, agencies have long seen children as an integral part of their clients' lives, and have done their utmost to offer support to battered mothers for their children. Indeed, advocacy agencies raised awareness of the needs of children of battered women, and the urgency of providing resources for programming, at a time when few outside funding agencies recognized the necessity of offering dedicated services for children.

Agencies differ in the way they approach services for children. While some agencies have delineated advocates who primarily serve women as *women's advocates,* distinct from those serving children (*child advocates*), other agencies term all advocates *family advocates* and yet others simply call all such staff *advocates*. The differences in terminology may reflect philosophical differences; they may also reflect the economic realities of limited resources. In this paper, the term *child advocate* refers to all staff members who provide services primarily for children. This does not imply that delineating some staff as child advocates is better than having advocates who serve all members of the family, but rather that, whatever the job title that is used, agencies serving battered women and their children should have staff members who possess some expertise in child development and resources/programming for children.

The core resource for many agencies is the child advocate, who may function variously as counselor, ad hoc babysitter, educational advocate, and case manager (A. Brickson, personal communication, January 20, 2002). Within larger agencies, dedicated teams of child advocates may organize and provide children's intake and assessment, support groups, recreational activities, educational advocacy, parenting support, legal advocacy for parents regarding their children (e.g. custody issues), and therapeutic interventions (including play and art therapy). However, many shelters and domestic violence agencies are small and may not have the staff, volunteers, or space to offer much formal support for young children.

Child-Focused Training Within Domestic Violence Agencies

In larger agencies where funding is available, child development experts may be brought in to consult and offer training. Typically, however, it appears that basic training around child issues for residential staff is incorporated into the overall training hours that staff are expected to

complete to fulfill program and state standards.[1] Such training may focus on mandated reporting laws about child maltreatment, and may include a short section on the impact of exposure to violence on children. Child development training does not appear to be a core part of staff training nationwide. Similarly, training in cultural competence, and particularly in understanding children, families, and childrearing within a cultural context, does not appear to be a core part of training.

State-Level Resources and Standards for Children's Programming

Depending upon the state, guidelines may be in place which represent minimum mandated service standards for agencies and programs serving domestic violence victims and their children. Again, the dearth of national data severely limits any generalizations regarding state standards or resources. Where these do exist, state standards for children's services vary significantly, and, as noted previously, vary partly as a function of whether or not state funding exists for children in domestic violence programs.[2]

Ultimately, these differences have resulted in a wide range of programming for and perspectives on the provision of children's services. State-level agencies and individual programs report the need to maintain a sometimes delicate balance between asserting the needs of children affected by domestic violence (and allocating resources to meet those needs) and taking care not to withdraw sometimes scarce resources from the adult victims, usually the mothers of those children.

It appears, however, that state domestic violence coalitions are increasing their focus on children. Data from an incomplete survey of state coalitions across the nation in 2001-2002 indicate that approximately two-thirds of states have a staff person or a working committee whose tasks include addressing the needs of children affected by domestic violence.[3] In addition, many coalitions are in agreement about the services that constitute *minimal standards* for children in domestic violence agencies (A. Brickson, personal communication, January 21, 2002). These include (a) a separate intake process for or regarding children, (b) an orientation of each child to the shelter or program, and an opportunity for children to talk about their experiences with domestic violence, if they wish, (c) age-appropriate support groups for children, (d) primary prevention programming in schools, and, (e) work with local child welfare/child protection agencies.

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[1] A review of program training standards for 7 states revealed that training specific to children's issues (including mandated reporting requirements) never constituted more than 15% of the curriculum (on average 3 hours per 20 hours of training).

[2] For example, in Iowa, state standards (developed by the Iowa Coalition Against Domestic Violence) mandate that all programs have at least one staff position designed to address children's issues. State funding is available to support children's programming.

[3] In a survey to ascertain the proportion of agencies with specific child advocacy positions, respondents at the state level (representing 8 states) reported that 45-90% of the programs in their state had at least one part-time funded child advocacy position (A. Brickson, Wisconsin Coalition Against Domestic Violence, personal communication, January 21, 2002). However, this may be an overestimation for the nation as a whole, since states without state-level child representation were not included in the survey.

Defining Good Practice with Young Children and Their Families

Although relatively little is known about effective research-based interventions with children exposed to family violence, much is known about the developmental needs of young children, and about the factors that promote their competence, as well as those that enhance risk (Cicchetti & Cohen, 1995; Masten & Coatsworth, 1998). Hence, good practice should encompass developmentally sound approaches to working with young children in the context of family, culture, and community. All advocates should have a basic knowledge of child development to help them support battered mothers and their children. Cultural competence is also crucial to communicating with children and their mothers and to understanding the cultural backdrop of a child's needs. Children's needs vary as a function of their developmental stage, as well as their individual, family, and community risk and protective factors. However, for all children who have experienced domestic violence and who are in residential programs, the challenges of separation and loss are salient: loss of home and belongings, and loss of or separation from at least one caregiver.

A sensitive approach to the family tries to acknowledge several realities. First, parenting under any kind of pressure is stressful, and it is particularly so when (as is the case in battered women's shelters) a single parent is caring for her children alone in a public place where she is essentially observed all the time. Respecting and supporting the role of the mother as primary caregiver is a critical staff task. This is particularly important given that a mother's parenting authority of her children may already have been undermined by the batterer (e.g., Bancroft & Silverman, 2002). Supporting mothers may involve anything from offering an empathic listening ear to accessing parenting resources and support groups.

Second, although many children "bounce back," with supportive parenting, from stressful and traumatic situations such as domestic violence, and/or the loss of home and school (due to a move to shelter), some children need individual help (via early intervention, counseling, or therapy) to do so. Partnering with the mother to support her in her role of parent, and, where appropriate, helping to access individual help for the child(ren), offer advocates an important role in strengthening a battered mother's parenting self-efficacy and in helping to promote resilience in her children.

Determining Children's Needs

A basic intake or screening (i.e., a structured introductory meeting) with all children and their mothers, including observations of pre-verbal children and interviews with children who are verbal, offers a solid basis for subsequent referral for services for children.[4] An intake gives mothers the opportunity to discuss how their children are doing, to share concerns, and to receive

[4] A screening tool is usually a brief procedure involving a questionnaire or structured interview format, with rapid turnaround time for results. It ascertains immediate risk and identifies problem areas warranting further investigation. An assessment usually involves further investigation of discrete problem areas.

feedback on their children's behavior and development. It gives staff the opportunity to gauge what services can best be offered to the child. Finally, in the minority of cases where children do require more intensive specialized help, it offers a first step toward accessing that assistance. For agencies which lack resources or manpower to implement a child intake or screening, partnering with local early childhood agencies for consultation and training can be extremely helpful. Screening achieves two broad objectives: (a) it identifies major areas of child need, including those that are unrelated to the domestic violence but that must be addressed, and (b) it enables planning of appropriate short- and longer-term interventions for the child and the family (Stephens, McDonald, & Jouriles, 2000). Except in cases of suspected abuse or neglect, screening should be entirely voluntary and conducted in a spirit of collaboration between shelter staff and mother. The intake process is an opportunity to build rapport with mothers, who often have not had the opportunity to talk about their children's and family's needs in a safe and confidential environment. Ideally, offering a window of time within which screening can be completed (e.g., within a week of entering shelter) provides mothers with control over its timing.

An intake or screening of every young child should cover his/her needs in the following core areas: physical safety, physical health and development/medical needs, social development, community and cultural links and supports, mental health, and (for preschoolers) school readiness. For immigrant families, or those from non-majority cultures, understanding the child's and family's level of acculturation, as well as ensuring that they have someone at the shelter with whom they can communicate, is critical.

Ideally, an intake should incorporate a standardized tool for which individual results can be compared with a comparable group of same-age children. For example, several domestic violence programs use the Ages and Stages Questionnaire (Bricker & Squires, 2001), which is completed by the mother (or by shelter staff, with the mother's help) in less than a half hour, and which gives valuable information to parents and staff about young children's development across various domains. Both the tool and the process used must be culturally valid and relevant in order to be appropriate for use with diverse groups. In some cultures, and for some families, quantitative screening tools are seen as intrusive, and in these cases a more individualized, qualitative assessment is appropriate.

Without a screening, child advocates often lack specific directions for their work beyond basic safety planning; the burden of the time such a screening takes can be more than outweighed by the hours saved in subsequent case management. However, if a program lacks the resources to conduct an intake or screening, or to use standardized tools, it is useful to connect families with local early childhood agencies that offer educational, developmental, and socio-emotional assessments of young children. Often these agencies require a referral from a service provider (such as a domestic violence agency), or that parents have significant, specific concerns about their children.

At the Harriet Tubman Women's Shelter, a 64-bed shelter serving the Minneapolis/St. Paul metropolitan area, a family resiliency team member meets with every child and mother entering shelter to undertake a basic screening and to complete a child and family safety plan. The shelter offers residents on-site daycare, and advocates encourage mothers to bring their children regularly. Children's presence at the daycare affords staff further opportunity to assess young children's development. When indicated, trained daycare staff members screen for developmental lags. Based on the results of the Denver Development Screening Test,[5] children may be referred as eligible for Zero to Three and/or other prevention and intervention services (Frankenburg, Goldstein, & Camp, 1971).

Assessing Women's Safety, Support, and Human Needs

The core work of domestic violence programs—safety planning and advocacy with battered women—is also essential to meeting children's needs. If battered mothers are safe from physical violence and have access to resources such as food, shelter, permanent housing, and income, their children will benefit significantly. As advocates work with adult victims, they should define women's safety needs broadly, and assess with each battered woman her physical safety, parenting support, and material needs. Through intake interviews and meetings with shelter residents, advocates can inquire about the following issues: Do women have access to income, job training, child support, and healthcare? Are they aware of disability or other benefits to which they or their children may be entitled? Are they interested in childcare resources and family support programs? Shelter training and intake procedures should reflect the importance of these areas of inquiry and assistance to families.

Offering Effective Intervention

The varying needs that may be presented by young children and their mothers, in families struggling with domestic violence and poverty, are illustrated in the following case example:

> *Ben was 30 months old when he arrived at the shelter with his mother following several dangerous assaults against her by his father. Ben aroused the concerns of the shelter staff, as he did not seem able to do the things that other toddlers his age could do: he walked awkwardly and tripped often, and his speech was monosyllabic and often incomprehensible. Socially isolated, though loving and nurturing, Ben's mother did not know other children his age with whom she could compare him. Based on the results of an initial screening conducted in the shelter, during which Ben's mother complained that he liked to play with peeling paint in their apartment, Ben was referred to a local clinic for a developmental assessment and lead evaluation, and was found to be suffering from lead poisoning. Medical and psychosocial interventions reduced the lead level. Psychosocial interventions helped Ben. A parenting support group in the shelter enabled Ben's mother to establish contact with other mothers of toddlers*

[5] The Denver Development Screening Test is a developmental assessment for use with children aged 0 to 4 years. It may be administered by a trained paraprofessional and takes about 40 minutes.

who were able to share their insights and concerns with her. When the mother requested child development resources, the group facilitator was able to access them (through a healthcare professional volunteer network).

Promising interventions meet the needs of both children and their mothers. For the children they address issues of health, safety, trauma, loss, and separation in a developmentally and culturally appropriate fashion and take into account that children are often viewing events through a different lens from their parents. For mothers, such interventions are culturally competent and support nurturing, authoritative parenting. One aspect of parenting—disciplining children—can raise difficult practice and ethical challenges for advocates as the following scenario illustrates.

During a parenting support group in a battered women's shelter, participating mothers repeatedly talked about the stress of parenting in a "public space" 24 hours a day. One of the most significant sources of stress was the concern that if a mother spanked her child (a culturally-sanctioned and appropriate method of discipline for several of the group members), then maybe an advocate would ask her to leave the shelter or might even report her to the Child Protective Services for abuse. These mothers felt strongly that they knew what was best for their children and knew how to help their children comply with shelter rules. In that same shelter, advocates spoke of their confusion around what to do if they saw a mother spank her child. Agency policies clearly prohibited hitting a child, yet advocates understood that asking a woman to leave shelter or calling CPS could just make things worse for the child and the mother.

The dilemma that this vignette raises is a very common one, not only within domestic violence agencies, but across many childhood contexts. However, the significant overlap between child abuse and domestic violence, coupled with the violent behavior that is modeled by the batterer, means that the tensions around this issue are often heightened within domestic violence agencies, and particularly in shelters. Some domestic violence agencies have successfully addressed this issue by promoting non-physical methods of discipline and offering mothers information and strategies (within an individual or group format) to promote positive, non-coercive parenting.

Meeting the Emotional Needs of Young Children

Staff within domestic violence programs who possess knowledge of child development can help mothers respond to the emotional needs of their children. For example, the natural reactions of young children to the stress of domestic violence and to leaving home for shelter might include clinginess, a greater than usual dependence on the mother, or nighttime fears. Staff can reassure mothers that these reactions are to be expected, and provide advice to them about ways to reassure young children (for example, by offering children extra attention). Pamphlets that describe common behaviors in children exposed to domestic violence can be very reassuring for parents and can also offer them guidelines for when to seek help from an outside professional.

In some cases, the intensity of children's reactions to domestic violence may require the intervention of mental health professionals. The degree to which mental health services can be useful for a child depends not only on the nature of the child's difficulties, but also on the degree of comfort and familiarity of the battered mother with such services. Here again, the cultural context of the family is important. For families (particularly those from non-majority cultures) who are unfamiliar or uncomfortable with mental health services, advocates trusted by the family may serve as a bridge to services, offering transportation or introducing the mother to other families who have received similar services. For distressed young children, early intervention opportunities, or intervention through pediatric care (i.e., developmental and behavioral pediatrics), may be viable alternatives where mental health professionals cannot be accessed.

In-house provision of mental health and crisis treatment services by domestic violence agencies has historically been a point of contention among providers. However, several shelters have successfully provided mental health or crisis treatment as needed to resident children, and have found ways to avoid the diagnostic labels that are necessary for insurance reimbursement. For example, the Pro Bono Children's Mental Health Project at Women's Center and Shelter of Greater Pittsburgh offers individual therapy for children from the time they are in shelter at least through their transition to permanent housing. The mental health project utilizes the expertise of in-house therapists as well as volunteer mental health professionals from the community (S. Regan, personal communication, February 6, 2002).

For those domestic violence agencies that do not offer in-house mental health services, children who need such help are usually referred to local clinics or practitioners specializing in domestic violence. The Homeless Children's Network (HCN) in San Francisco offers no-cost mental health services to any child in any shelter in the city. Funded largely through a grant from the mayor's office, HCN offers individual and family therapy without preset time limits to battered mothers and their children. Mental health professionals continue working with children through their transition to a stable living environment, and act as mental health case managers for children with more complex problems. Therapists conduct both office- and home-based treatment, and consult with childcare providers and schools (A. Silas, personal communication, February 13, 2002).

Support groups for children of battered women are arguably the most documented interventions for these children (Marshall, Miller, Miller-Hewitt, Sudermann, & Watson, 1995; Peled, & Davis, 1995). Several non-residential family violence agencies provide well-established support groups for children. For example, the Domestic Abuse Project in Minneapolis runs concurrent children's support groups and parenting groups, so that mothers can feel comfortable, knowing that their children are well cared for and engaging in parallel activities (Peled & Davis, 1995). Despite the well-established use of support groups for children of battered women, groups have not been specifically developed and evaluated for preschool children.

Meeting the Educational Needs of Young Children

Healthy development is at least in part predicated upon the stability of caregiving and daily life that is often lost as the result of moving to a shelter. Hence, helping the primary caregiver to provide and maintain as much of the prior routine as possible (remaining at the same school or childcare provider, where possible) is essential, unless it compromises the child's physical safety.

Shelters are best placed to provide for the educational needs of young children, with the role of non-residential domestic violence programs primarily being referral to programs such as Early/Head Start and Zero to Three. Although most shelters do not possess either the financial resources or the capacity to house a daycare, having an on-site daycare is far preferable to placing children in ad-hoc babysitting with different staff members, or to finding a temporary daycare arrangement.

Meeting Security and Attachment Needs: Supporting Families

Taking a family-centered approach, particularly in residential services, recognizes the critical importance of supporting the mother-child relationship (Saathoff & Stoffel, 1999). At the Women's Center and Shelter of Greater Pittsburgh, for example, a weekly "moms and kids" night affords mothers the opportunity to play in structured activities with their children, with parenting support available from facilitators. At the Harriet Tubman Women's Shelter in Minneapolis, family resiliency team members (similar to child advocates in other agencies) offer structured recreational family activities 1-2 nights a week and on weekends, as well as individual parenting guidance where requested. Recreational activities include cultural and religious heritage celebrations (e.g., for Cinco de Mayo, Kwanzaa, Chinese New Year). In addition, mothers have the opportunity sometimes to cook communal meals for shelter residents that celebrate their cultural traditions.[6] Parenting support groups are also frequently offered by domestic violence agencies, and are most useful when they are completely voluntary and when facilitators with expertise in child development are available to offer help.

Advocates can also provide individual support for families. For example:

> *While meeting with an advocate to discuss safety planning for herself and her son, Jane, age 24 and the mother of a 3-year-old boy, raised concerns about her son. "Instead of listening to me and staying in his room when I asked him to—when my husband was being abusive—he would yell at my husband and sometimes run to try and "protect" me. Now he is sometimes totally out of control; he yells and screams, kicking and hitting, and using the bad words that he has heard his dad use. I'm worried that he's going to be abusive, like his dad." The advocate responded that she felt it must be very stressful to worry both about her son's safety, and also about the behaviors that she thought he was learning. "It sounds like you love and care so much for your son, and you know where this behavior comes from, but you aren't sure how to deal*

[6] Mothers report that the inability to cook for themselves and their children (and to eat what they usually eat at home) is a particularly stressful aspect of life in a shelter.

with it." The advocate referred Jane to a local early childhood agency, while reassuring her that, developmentally, tantrums are not unusual for a three-year old.

The early childhood specialists were able to help Jane understand the developmental and environmental context of her son's behavior, and find effective ways to deal with it.

Providing for Physical Safety

While safety planning has always been a core aspect of domestic violence programs, children have not always been included in the process of developing a safety plan together with their mother. Increasingly, however, children are actively participating in safety planning, either by doing their own safety plans directly with children's advocates, or participating with their mothers in family safety plans. The latter type of safety planning recognizes the mother as the primary protective figure, allowing for all family members to have the same plan and to know what to do in case of emergencies. Although young children need to be of an age where they can understand what safety planning involves, children as young as 3 can participate.

Offering Transitions to Permanent Housing and Longer-Term Interventions

Home-based services can provide valuable support in the transition from shelter to permanent housing. In Michigan, the Families First program has successfully offered in-home help for families at risk for homelessness or from an assailant, and for those making the transition from shelter to permanent housing. Advocates, funded through Families First and working out of domestic violence shelters, visit the home from 5 to 20 hours a week, and are available 24 hours a day to help parents with safety and concrete needs, advocacy, and parenting. Funded by TANF (Temporary Assistance to Needy Families) dollars, the program has successfully demonstrated a decreased involvement with child protective services by participating families. In addition, empirically-validated programs in Michigan (Sullivan & Bybee, 1999) and Texas (Jouriles et al., 2001) provide home-based advocacy and/or parenting support for battered mothers. It is important to recognize that, just as leaving an abuser is not usually a single-event phenomenon, intervening to help families in their transition to new lives may take time.

Maintaining Confidentiality and Sharing Information

Advocacy with battered women and screening/assessment of young children raise issues regarding confidentiality and mandated reporting. For example, conversations with battered mothers, or the screening of children, may uncover information that would hinder a woman's pursuit of custody or require a report to child protection. Additionally, some referral agencies may misinterpret information shared by a domestic violence program and generate additional risks for the woman or child. Domestic violence agencies will need to review confidentiality policies and plan for the education and training of new referral agencies.

Practice and Policy Recommendations

1. *Domestic violence organizations should establish minimum competency standards for working with young children and should train staff to meet those standards. Job requirements should include prior work experience with young children. Training should incorporate content on child development, assessing children's exposure to violence and child abuse and neglect, supportive interactions with parents, building relationships with local early childhood resources, and procedures for reporting child maltreatment and advocating for mothers and children within CPS. All training, supervision, and consultation should be culturally competent and relevant, but this is particularly important in discussing and appreciating cultural differences in childrearing and discipline.*

2. *Domestic violence organizations should assess the emotional, physical, and educational needs of young children, with the permission of their mothers. Domestic violence organizations should also assess women's safety, parenting support, and material needs (e.g., securing a job, benefits, child support) in order to provide meaningful help to families.*

3. *Child advocates within domestic violence organizations should be equal members of advocacy teams whose goal is to foster the health and well-being of the woman and her children.*

4. *Domestic violence organizations should establish meaningful collaborative relationships with a broad spectrum of agencies that work with young children and their families. For example, shelters that collaborate with medical providers (either through visiting nursing services, volunteer healthcare professionals, or residency programs) help their clients receive healthcare that may not otherwise be accessible, particularly for low-income clients. In addition, checking that children are up-to-date on their immunizations, and ensuring that each family has a primary medical provider (and that all children have health insurance) should be key health outcomes for domestic violence agencies. Similarly, connections with early childhood systems within the community (such as Birth to Three and Head Start) offer those agencies an opportunity to learn about the developmental effects of family violence and offer children of battered women a chance to receive educational advocacy and services for high-risk children. Finally, connections with culturally-specific resources, as well as faith community resources, can lead to greater access to language/translation resources for clients, facilitate clients' support within their own communities, and enhance the awareness and sensitivity of faith and cultural leaders to domestic violence issues.*

5. *Because of the significant overlap of domestic violence and child maltreatment, advocacy must include strategies to protect abused women and maltreated children in collaboration with child protective services. Each organization should establish procedures and training*

that provide meaningful guidance to staff about when a mandated report of child abuse or neglect is necessary and what process to use when making such a report. Support and advocacy for battered mothers and their children should continue throughout the entire CPS process. Advocates should also work collaboratively with community, court, and/or social service agencies to establish interventions with domestic violence perpetrators that protect children and battered women.

6. *Policies should be implemented at state and local levels enabling battered women's shelters with licensed childcare to access funding for early childhood and preschool programs.*
7. *Home-based family support initiatives should be available to battered women and their children through a portal other than the mandated Child Protection System.*
8. *State coalitions should encourage the development of guidelines for the screening of children's physical, emotional, and educational needs while they are residents in domestic violence programs.*
9. *Minimum competency guidelines should be established for child advocates working with young children.*[7]
10. *Blended funding streams should be used to provide children exposed to domestic violence with the mental health services they need—without requiring a diagnosis. Mental health dollars, as well as victim assistance dollars, should be allocated towards providing crisis mental health services where the referral criterion is the incident rather than the child's diagnosis.*
11. *Staff in domestic violence agencies are often faced with clients and their children who come for help with issues related to domestic violence that may include multiple traumatic stressors. Advocates are sometimes faced with stories of intergenerational abuse and trauma for which they can offer little more than empathic listening, but which can be profoundly difficult to hear. Offering regular consultation to staff on client-related issues, as well as emotional support, is important to preventing burnout and to enabling them to continue to help battered women and their children. In addition, maintaining a predictable, supportive environment which offers safety, structure, and nurturance, and which meets the needs of children and their battered mothers, can help support both clients and staff.*

[7] See, for example, guidelines developed in Wisconsin (Wisconsin Coalition Against Domestic Violence, early 1990's).

Part II.
Batterer Intervention Programs

My Daddy is a Monster
He hurts my mommy
He hurts me too
Sometimes he hits
Sometimes he says things
That scare me and
Make my mommy cry
After he leaves
Sometimes I wish he
Won't come back – ever. I love my daddy.

Source: National Coalition Against Domestic Violence, author and date unknown.

Abusive Men as Parents

Children are affected in dramatic ways by the violent behavior of the father or father[8] figure in their lives. The preceding poem illustrates what Peled (2000) suggests—the internal struggles and the split between mother and father that children often face when witnessing or directly experiencing family violence. Additionally, according to Peled (2000), children develop an image of their father not only from their personal experiences but also from the reactions of social systems and agents that may or may not intervene when violence occurs in the home. Thus police visits to the home, shelter stays, and participation in domestic violence programming all play a role in the way a child perceives his father. In addition, interactions between the mother's family and the man who batters will also have an impact on the children's perception of their father.

Bancroft and Silverman (2002) define a man who batters as one "who exercises a pattern of coercive control in a partner relationship..." (p. 7). While actual physical violence may not take place, the threat of such violence is made clear through coercive actions and threats. The spectrum of abuse is wide. Bancroft (2002) suggests that the key characteristics of men who batter also have profound implications for their parenting and their children. For example, a man who batters may exercise control to undermine the woman's parenting, or assault her when angry over his children's behavior. His sense of entitlement may lead him to assault his partner because he believes that she is paying more attention to the children than to him; his possessiveness may lead him to see his children as objects for his own use (or abuse), rather than as individuals in their own right. These characteristics can lead to parenting that creates family divisions and pits children against their mother (Bancroft, 2002).

[8] This paper uses the word *father* to refer to an adult male engaged in a significant relationship with a battered woman with children, or living in the same household.

Men who abuse their partners may also be maltreating their children psychologically by exposing them to terroristic, self-destructive, and rigidly controlling behavior. A high percentage of men who assault women also physically abuse and neglect children (Carter & Schechter, 1997). In addition, men who batter are modeling violent behavior to their children, and may be contributing to long-term psychological and behavioral effects. Often these men do not examine the harmful impact that their use of violence has on the children who are exposed to it (Brassard, Germain, & Hart, 1987; Garbarino, Guttmann, & Seeley, 1986; Maddock & Larson, 1995; Peled, 2000). Researchers have identified other ways in which domestic violence can negatively affect children, and these include forcing children to keep the "secret" of family violence, increasing the family's stress and instability, and creating transient living situations and economic difficulties (Blanchard, Molloy, & Brown, 1992; Maxwell, 1994; Peled, 2000).

Populations and Offered Services

A wide variety of programs provide intervention for men who batter. However, most programs are designed for men who are arrested or would be arrested if their violent behavior were public (Bennett & Williams, 2001). Some programs are offered through private, non-profit agencies; others, through public agencies such as probation departments; and still others are organized by domestic violence services. Eighty percent of men in these intervention programs are referred by the court, following an arrest (Bennett & Williams, 2001).

Guidelines or standards for intervention programs also vary. Some programs have a goal of ending criminally violent behavior; others focus more broadly on ending coercion and violence; most teach alternatives to violence. Program length may be as long as 52 weeks in a few states, although in many localities 12 to 26 weeks is the norm. As far as we know, no statewide standards exist that mandate the inclusion of parenting or child development information in intervention programs for men who batter. In some states, standards do require the inclusion of information on the impact of domestic violence on children (A. Ganley, personal communication, 2002). There is no information as to the number of programs for men who batter that explicitly include parenting, child development, and the importance of the father-child relationship as key content in their intervention services.

Programs that work with men who batter are charged with four goals: legal justice and accountability (Healy, Smith, & O'Sullivan, 1998), victim safety, emotional development, and change in attitude and behavior (Austin & Dankwort, 1997; 1999). Particular programs may place a different emphasis on each of these goals and may offer different approaches to achieve them. For example, some programs may use psycho-educational and cognitive/behavioral methods for change, while others may believe a more insight-oriented therapeutic approach is needed. There may even be different outcomes for success. A 26-to-52-week program that may not be more effective than a shorter term program in rehabilitating men who batter, may be seen as successful because it provides a longer period of legal accountability and victim safety (Bennett & Williams, 2001). No particular program approach has been shown to be superior. Therefore,

program experimentation that does not jeopardize the safety of adult or child victims must be supported. Safe program development can be accomplished by working collaboratively with victim advocates; victim service agencies; family, marital, and individual therapists; and criminal justice authorities (Bennett & Williams, 2001.)

In some low-income areas and communities of color, a significant degree of stigma is attached to programs for men who batter. Because many of the programs for men who batter place paramount emphasis on legal justice, victim safety, and using criminal legal system sanctions to enforce accountability, some communities interpret batterer programs as anti-male. These programs may strive to help men stop battering, but may also place additional mandates[9] on participants which they are unable to meet. This can result in their dropping out or being unable to successfully complete the program. This dynamic also furthers the perception that the program's function is solely legalistic and punitive.

Some women of color or women in poverty are particularly affected when punitive language is used to explain programs for their partners. Punitive and directive language (e.g., "You must call the police" or "Your partner must admit he is an abuser") may further the fear and community distrust of programs for men who batter, particularly within communities of color. As a result, women may not recognize that parts of the program may help them and their children, such as aiding their partners in regulating their emotions and developing self-control. Some women may not seek help when they are abused because they believe the only options are punitive and intrusive for their families. Programs that serve men who batter must balance the important social and legal considerations with therapeutic skill and technique. It may be necessary to restructure batterer intervention programs so that they can be viewed as a community resource that protects young children and serves their families.

It is difficult to make generalizations about men who abuse their partners. However, it is widely known that men of color are referred to court-ordered treatment programs at a disproportionate rate relative to the overall population of men who batter, possibly because these men represent a large proportion of the lower socio-economic population, and men at higher income levels may find other ways of satisfying treatment requirements. This knowledge should limit generalizations from studies that utilize information from court-ordered programs.

Ed Gondolf (1995) investigated some of the characteristics of men who were court-referred to programs for men who batter. The majority of participants were men of color, in their early 30s, of lower socio-economic status, with a problematic family background that included childhood exposure to violence and/or substance abuse. Many men studied had behavioral problems that went beyond their domestic violence, and some of these men had diagnosed personality or major mental disorders. Yet another common finding in Gondolf's study was that men who batter often minimized the severity of the abuse they committed. This last finding highlights the importance

[9] For example, programs might require a participant to be employed, to pay a level of child support that is beyond the participant's means, or to stop abusing drugs or alcohol without offering treatment.

of both evaluating a man's parenting "risk" status, and intervening to address parenting issues in programs for men who batter (Gondolf, 1995).

Gondolf also asserts in his multi-site evaluation of batterer intervention programs that,

> At 30 months, men who completed 3 months or more of the programs for men who batter were significantly less likely to have re-assaulted a female partner (36% of the completers re-assaulted vs. 51% of the dropouts). The vast majority of men eventually were not violent for a sustained period. There was no significant difference in re-assault rates across African American, Latino, and European-American men. (p. 12)

Some men do change their behavior through community cultural interventions and mandates, such as restorative justice, tribal circles, and church and elders' interventions. One of the most under-observed interactions is that of cultural and community sanctions against domestic violence behavior. Sometimes an approach that recognizes the possibility of legal consequences with restorative community practices can be beneficial to families. The following paragraph is an example of a cultural intervention.

> *Jefferson is a 42-year-old Native American man who, during the first 7 of his 10 years of married life, used physical force against his wife. None of the elders in his community who knew of the abuse chastised his behavior or suggested sanctions against it, thereby reinforcing his violence. Two years ago however, as the community became stronger, and the elders became more knowledgeable regarding domestic violence, they began to bring him into tribal circles and weekly elders' meetings to caution him about his behavior and the impact of it on his community and his children.*

Resources Addressing Parenting in Programs for Men Who Batter

Little exists in the research or practice literature that addresses the parenting capacity of men who batter. Though in some cases these men will be denied access to their children out of justifiable concern for their safety, in many cases they will continue to see their children. Concerns for the safety of mother and children following separation from an abusive male are important. This is particularly pertinent given the evidence that harassment and abuse often increase following separation (Schnarch, 1997; Sev'er, 1997). However, the benefits for both children and father, when contact can be continued safely, are important to consider. Men who have been previously violent in their families and now want to change their behavior may have an opportunity to have a positive impact on their children's developmental path and lessen the impact of their negative role-modeling and behavior patterns (Perry, 1996; Perry, Pollard, Blakely, Baker, & Vigilante, 1995). Additionally, when fathers have a good understanding of appropriate child behavior at different developmental levels, their expectations are more realistic, and family conflicts over children may be reduced.

Many programs for men who batter seek to hold men legally accountable for their abusive behavior. However, many programs may miss the opportunity to (a) help men develop a sense

of self while they are in a relationship; (b) lower their reactivity to their partner and children; (c) aid in their development of discomfort tolerance, for the possibility of growth; and (d) assist in the mastery of techniques that help men self-soothe their own hurts and pains (Schnarch, 1997). Program aims should be to help men develop the capacity to hold themselves accountable for their behavior toward their children and partner.

Many programs conduct their interventions as if all men who batter are the same. This does not take into account the reality that men come from different backgrounds and cultures, commit different levels of violence, and have very different capacities for change.

Programs for men who batter also should serve as a conduit for other programs that provide for the material needs of men struggling with poverty, substance abuse, and mental health issues.

Assessing Men Who Batter as Parents: Considering Safety and Risk

Bancroft and Silverman (2002) suggest that in assessing the risk that a man who batters presents to his child(ren), several aspects of current and past behavior must be evaluated. In relation to the children, these include the abuser's history of

a. physical and sexual abuse (and boundary violations) toward the children;
b. neglectful and under-involved parenting;
c. psychological cruelty;
d. willingness to risk physically or emotionally hurting the children incidental to partner abuse;
e. using the children as weapons, or undermining their mother's authority; and
f. risk to abduct the children.

In relation to the batterer's current and past behavior toward his partner or ex-partner, factors that must be taken into account include

a. physical danger to the partner/former partner;
b. the level of coercive or manipulative control exercised over the abused partner;
c. the abuser's level of selfishness, self-centeredness, or feeling of entitlement;
d. his substance abuse and mental health history;
e. his refusal to accept the end of a relationship or the beginning of a new one on the part of a former partner; and
f. his level of refusal to accept responsibility for past violent or abusive acts (Bancroft & Silverman, 2002).

No known national study describes the questions about children that appear on intake forms for men who are entering batterer intervention programs. Nor is there a literature on the interview questions typically used, in programs for men who batter, about their children's exposure to

violence. Although some batterer intervention programs probably ask about Child Protective Services investigations and about court orders for custody and visitation, many programs conduct only minimal reviews of the risks to children and their needs (J. L. Edleson, personal communication, 2002).

Several variables must be taken into account when considering parenting issues in the context of interventions with men who batter. Mederos and his colleagues suggest that three factors about the men who batter are important with regard to the safety of children (Mederos, 2000). The first is parenting capacity. Does the abuser have the capacity to be a responsible caretaker? Is there a method developed that can both systemically and culturally evaluate parenting responsibility and the care-taking ability of men who batter? Will the father neglect the child? Some men dealing with poverty may be unable to access the "responsible care-taking opportunities" of other men (e.g., day care, parenting classes). Secondly, there should be a concern about danger. Does the abuser pose a threat to the mother or child, and are there safety concerns regarding ongoing contact? Is there a history of violent behavior towards the children and the mother? Is there a history of obsessive or threatening conduct? Will the father be abusive toward the child? Finally, intervention programs for men who batter should take into account the man's parenting style. What is his behavior with the children? What role did he play in the raising of the children? What is the nature of the relationship between father and child?

Additionally, attention must be paid to the manipulative factors that some batterers employ to gain access to children and partners. Service providers should be aware that some men might use the area of parenting as a tool of collusion. Sometimes a manipulative man will convince the service provider to write letters to the court suggesting a high level of parenting capacity, or to support child visitation.

When assessing other types of violent behavior, standardized risk assessment tools have been shown to be more reliable and valid than clinical evaluations based on risk markers (Dutton & Kropp, 2000). While such standardized tools are commonly used with sex offenders and violent offenders in general, no such tool exists to evaluate the men who batter—their violent behavior toward their children, and/or the risk level a batterer presents to his children (Bancroft & Silverman, 2002). Also, there are no scientifically tested methods of predicting future risk to a batterer's children or adult victims.

The next step in the field is to develop an evaluative instrument that balances the legal, therapeutic, and cultural issues. There is clearly a need for an instrument sensitive to culture and poverty, given what is at stake for women and young victims and witnesses of domestic violence.

Effective Parenting Interventions in Programs for Men Who Batter

When provided by a trained facilitator, the introduction of information on child development, the effect of exposure to violence, and the role of fathering can be an important tool that serves a number of purposes:

1. It gives the father a greater sense of understanding about children's experiences. Many men have little information on how a child develops or the effects of exposure to violence.
2. It gives fathers an opportunity to see how their behavior impacts their children, and offers them alternative ways to parent and to interact with their child's mother.
3. It encourages men to examine the impact of their fathers on their own lives. It provides the abusive man an opportunity to deal with family-of-origin issues and connect the meeting of their children's needs to the realities of his past.
4. It can encourage men to explore the use of non-abusive behaviors for the sake of their children. It can motivate the men to change.

The following example from Tubman Family Alliance in the Twin Cities Metro Area in Minnesota illustrates the importance of addressing child issues within treatment for men who batter.

> *Delvon, a 21-year-old African American man, was convicted of assault on his partner. He and his partner have a 4-year-old son together. During a session in which Delvon was discussing the conflicts between him and his partner, a clinically trained African American professional asked Delvon if he had ever seen that behavior before. Delvon stated that he had seen his uncle deal with his aunt that way. The aunt and Delvon were very close to each other. Delvon was then asked what he did when his uncle hurt his aunt, and how he felt about it. Delvon was also asked about how these interactions had an impact on him in relationships with other Black men and women. He was asked what it was like to be in their home when the conflicts occurred. How did he express himself, and with whom did he talk about his feelings? Then the therapist asked Delvon, "What do you think your child thinks when you act like your uncle? And what does your child do when you act like your uncle?" These exchanges integrated the past with the present to explain and confront existing patterns. Delvon had never thought about how his child was coping, and was able to do so only when he connected to his experience and past victimization. Exploration of thoughts, feelings, and culture can be an effective way to get men who batter to self-confront, and to change their behavior over time.*

Promising interventions for men who batter include information about parenting, as well as the effects of violence on children, as part of their core programming. This information can be introduced in groups for men who are abusive or in groups that specialize and focus on parenting. One such program is the Men's Parenting Program at the Wilder Foundation Community Assistance Program in St. Paul, Minnesota. Program interventions include helping abusive fathers confront themselves about the effects of their behaviors on their children, giving fathers the opportunity to understand their children's developmental stages, helping men face their violent behavior, and assisting them in developing new parenting practices (Mathews, 1995). The Wilder Foundation has also developed groups specifically for African American men, with a culturally competent African American facilitator.

Mathews (1995) suggests that men who batter face significant challenges when learning how to parent more appropriately. These include (a) their limited knowledge of child development; (b) their shame, and a lack of empathy for their children's experience of their violence; (c) their ignorance about step-parenting; and (d) their unwillingness to make a commitment to non-violent parenting.

The Evolve Program, an intervention curriculum developed in Connecticut for men who batter, devotes six sessions to domestic violence and fatherhood (Donnelly, Norquist, Williams, & Wilson, 2000). Participating men are expected to create a plan to address their abuse with their children; improve their fathering if they have ongoing contact with their children; and learn how to be supportive and respectful of partners or ex-partners, regardless of their relationship status. Evolve requires men to comply with all court-mandated orders and with the wishes of partners/ex-partners regarding family safety and ongoing contact.

The Evolve curriculum provides the opportunity for men to make amends to children for their past or current destructive behavior, assuming that their former partner and the court allow the contact (Donnelly et al., 2000). The curriculum is designed so that men without ongoing contact with their own children can learn to behave in healthier ways in the future with the children of their relatives or new partners. The program does not distinguish between biologically- and non-biologically-related male caregivers when assessing the impact abusers have on victims, or in its requirements for positive change.

Haddix has suggested that an abusive father who is trying to lead a non-violent life and reconcile with his children should also consider successfully completing a time-limited treatment program for men who batter (1996). This program should include a separate parenting component. Fathers should also consider ongoing individual treatment. The abusive father should commit himself not only to ceasing violent behavior, but to desisting from any behavior that may endanger his children (e.g., alcohol/drug abuse).

Practice Recommendations for Batterer Intervention Programs

1. ***Design intake procedures, in intervention programs for men who batter, which include gathering information about (a) protection, custody, and support orders; (b) Child Protective Services investigations and juvenile court involvement; (c) the client's abuse and neglect of children; (d) the client's ongoing involvement with his children and their mother; and (e) what the client needs in order to be a responsible parent. Intake procedures in programs for men who batter should take into account specific cultural information, material needs, and culturally competent responsible fathering.***
2. ***Prepare intervention/prevention curricula for men who batter which incorporate content on (a) child development, (b) the impact of domestic violence and coercion on children, (c) healthy and non-abusive parenting, (d) responsible fathering, and (e) the individualized nature and context of each situation and the various environmental dynamics in which***

battering can occur—all while taking care not to support interactions that are dangerous or manipulative to mothers or children.

3. *Incorporate education on how responsible fathering can promote resilience in children, and how positive interactions between the father and the child's mother can support the child's healthy development.*
4. *Require that clients comply with court orders and have respectful, non-violent interactions with their child's mother.*
5. *When families do reunite, encourage the perpetrator to seek continued treatment and support—such as individual, family, and couple treatment—where applicable. The continuation of support to adult victims and to children within the family is also essential. It is important that professionals help perpetrators develop skills that reduce the use of high conflict interactions over their children.*
6. *Explicitly support ongoing programming, in addition to incarceration, for men who have completed interventions for men who batter, and who have subsequently re-offended.*
7. *Develop programming that is flexible enough to deal with differences—in their psychological frameworks, as well as their cultural backgrounds—in the men who batter and seek treatment.*
8. *Conduct regular recidivism checks on men who have battered, not only to identify safety concerns, but to be alert to men and families that may be struggling, so that additional services may be offered.*

Policy and Research Recommendations for Batterer Intervention Programs

1. *Support should be provided to conduct a national review of standards and promising practices for parenting interventions within intervention programs for men who batter.*
2. *An ongoing dialogue should be supported among intervention programs for men who batter, domestic violence agencies, culturally-based community organizations, child mental health organizations, child witness organizations, and responsible fatherhood programs, to increase understanding, develop a common language among these fields, and promote shared content about responsible parenting.*
3. *Research must be supported to clarify the nature of the risks to children from men who batter.*
4. *Funding should be provided to support the development of assessment tools about batterer risks to children experiencing domestic violence, and interventions to reduce them.*
5. *New and innovative ways of working with men who batter, with an emphasis on practitioner skill development, should be encouraged.*

About the Authors

Abigail Gewirtz, Ph.D., is a child psychologist and Clinical Assistant Professor at the University of Minnesota where she teaches and conducts research in the Psychology Department, and at the Institute for Child Development. She is Director of Research at Tubman Family Alliance, one of the largest family violence resource agencies in the US, where she coordinates the Minnesota Child Response Initiative, a multi-system, multi-agency collaborative to address children's exposure to violence. Formerly Director of Operations for the National Center for Children Exposed to Violence at Yale Child Study Center, Dr. Gewirtz has worked clinically with children and families exposed to violence, and has provided training and technical assistance to communities across the nation implementing multi-system efforts to intervene with children exposed to violence.

Resmaa Menakem, M.S.W., has more than 13 years experience working with families and individuals facing complex life situations, particularly with people of color, and currently serves as Director of Therapeutic Services at Tubman Family Alliance in Minneapolis. This innovative program, which Mr. Menakem helped to develop and implement, addresses the intrapersonal process used to heal men and women with abuse behaviors. He is also responsible for the development and management of a curriculum that addresses core structural issues including violence, racism, and oppression. He has previous experience at many social service organizations and is a founding member of the Stay Alive Project, a multi-agency collaborative focused on ending violence among male youth of African descent.

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Early Childhood
Domestic Violence
Poverty

Young Children's Exposure to Adult Domestic Violence: Toward a Developmental Risk and Resilience Framework for Research and Intervention

Series Paper #6

Introduction

Ruth, a woman in her mid-twenties, was four months pregnant when her partner began physically abusing her, and the abuse continued unabated for the next five years. Her son, James, was born at 34 weeks gestation, and was described as a "difficult" baby who cried often and slept for only short stretches. At seven months, James was diagnosed with "failure to thrive" syndrome; he weighed only 8 pounds and did not eat solid foods. Ruth was put on a waiting list for home-visiting services, but was told to expect a wait of several months due to the large demand for such help in her neighborhood. By 30 months, James was still underweight and was showing signs of developmental delay—he walked clumsily and spoke only single words. His relationship with his mother was described as "difficult"—his tantrums frequently escalated to destructive frenzies, during which he would throw heavy objects and bang his head, causing him to bleed and bruise. Ruth told her pediatrician that she would like to attend parenting groups with her son, but none were free and available in her neighborhood.

Divon was born at 35 weeks gestation to 17-year-old Theresa, who was a victim of ongoing physical abuse from her boyfriend, Divon's father. Theresa was enrolled in a high school with a special program for teen mothers, which included daycare and home-visiting services. During weekly home visits, which Theresa took care to schedule when her boyfriend was at work, the nurse helped Theresa attend to and anticipate Divon's needs. When Divon turned two, and Theresa graduated from high school, she registered her son for Early Head Start, which he attended daily through kindergarten. Theresa described her relationship with her son as "challenging but enjoyable." Theresa lived close to her mother and extended family members; when Theresa sensed that her partner might become abusive, she sent Divon to stay with his grandmother or with another member of her kin. Theresa was very affectionate and authoritative with Divon, but not punitive in her discipline. At 30 months, Divon was reported by Head Start staff to be a rambunctious, enthusiastic child, who was developmentally within the average range.

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According to a developmental perspective (Cichetti & Cohen, 1995; Rutter & Sroufe, 2000), a child's adaptive functioning results from a complex interplay among individual physical and mental capacities, developmental stage, and external factors in the social and physical environment (e.g., caregiver, family, community). As the examples above illustrate, domestic violence can variably affect a child's development, depending on other individual and environmental influences.

Research over several decades has informed us about the impact of children's exposure to risks and protective experiences (Masten, 2001; Rolf, Masten, Cicchetti, Nuechterlein, & Weintraub, 1990; Rutter, 1987). Risk factors are variables that are associated with an increased likelihood of poor physical, emotional, and behavioral outcomes. Examples of risk factors for children include premature birth, conduct problems, parental mental illness or substance abuse, physical abuse, exposure to violence, homelessness, and poverty. Most researchers agree that risks of a chronic, rather than an acute, nature are most likely to have damaging long-term effects (Garmezy & Masten, 1994). For example, the effects of a disadvantaged environment—poverty, racism, crime, and instability—are likely to create ripples of disadvantage throughout a child's life. The case examples above illustrate that these risk factors often co-occur in time; hence, what may seem to be the result of a single risk factor (e.g., poverty) may in fact be the result of other correlated but unmeasured adversities (e.g., inadequate community resources, exposure to violence, dangerous neighborhoods). Exposure to domestic violence may frequently co-occur with other risk factors such as poverty and its consequences, and other types of violence such as child maltreatment and community violence (Edleson, 1999b; Rudo, Powell, & Dunlap, 1998). This makes the unique effects of exposure to domestic violence hard to separate from those of other risks in a child's life.

Protective factors, on the other hand, are those variables that buffer children from adversity. Research on protective factors originated with longitudinal studies of high-risk youth who, despite the odds, matured and adapted successfully (Garmezy & Masten, 1994; Werner & Smith, 1989, 1992). Examples of protective factors include individual factors, such as the child's positive temperament, intellectual capacity, and social competence; family or interpersonal factors, such as caring adults, secure attachments to caregivers, and strong relationships with others; and cultural, ethnic, or community factors, such as living in a supportive, safe community.

Risk factors act both directly and indirectly to render children vulnerable to poor developmental outcomes (Luthar, 1993; Rutter, 1987), and the relationship between risk factors and outcome may be affected by specific aspects of the child's environment. Similarly, protective factors may act directly to protect children from poor outcomes; they may also ameliorate the impact that violence exposure has on a child's functioning. For example, since domestic violence occurs in the home, we may expect that additional variables—such as parenting, the home environment, and social support—will influence how exposure to domestic violence affects young children. As the case example of Divon and his mother illustrated, positive attachments, an extended family or kinship network, and the additional supports of educational opportunities and home visiting, may

all have acted to protect him from potentially grave outcomes related to domestic violence in the home.

Research on risk, resilience, and protective factors can offer a framework for answering questions about the potential negative effects of domestic violence on child functioning and how children might be protected from them. Longitudinal studies of risk and resilience among high-risk children have revealed factors that enable children to overcome chronic adversity (e.g., Block & Block, 1980; Garmezy & Masten, 1994; Radke-Yarrow & Sherman, 1990; Werner & Smith, 1992). Due to the paucity of data from longitudinal studies that look at exposure to adult domestic violence, the specific protective factors for these children are not yet known. A developmental risk and resilience perspective may, however, provide a framework to guide efforts to understand protective processes in the development of children exposed to domestic violence.

This paper examines the impact on young children of exposure to adult domestic violence through a developmental lens focusing on risk and resilience. We review the major developmental tasks of early childhood and draw on existing literature about the effects of exposure to adult domestic violence on young children in order to chart its potential effects over the course of development in early childhood. In doing so, we bring together two separate literatures, one on development in high-risk settings and the other on children exposed to adult domestic violence. Unfortunately, these literatures have remained largely isolated from one another. This paper employs the integrative framework of a developmental risk and resilience perspective to weave these literatures together and suggest where additional research is needed. The paper ends by pointing to the promise that early interventions hold for helping children who are living in poverty and exposed to adult domestic violence.

Developmental Tasks in Early Childhood

Every child, whether exposed to violence or not, must negotiate a series of milestones in order to achieve healthy development (e.g., Cicchetti & Cohen, 1995). Although many aspects of child behavior and parenting differ around the world, milestones are remarkably similar across different cultures and societies (e.g., van IJzendoorn & Kroonenberg, 1988; McCabe, Hernandez, Lara, & Brooks-Gunn, 2000). As there are many key milestones for children from birth to five years of age, we select those we think most relevant to understanding the impact of domestic violence exposure: (a) the development of a secure attachment relationship with a caregiver (usually the mother), (b) the beginning development of a self-regulatory system that enables a child to exercise control over emotions and behaviors (Sroufe, 2000), and (c) social and peer relationship skills that ready a child for entry to school (Oden, 1987).

Attachment

Decades of research on attachment—the bonds of love between child and parents—have revealed the importance of a secure attachment relationship with a primary caregiver, usually the child's mother, for later healthy functioning (e.g., Bowlby, 1969/1982, 1973, 1980; Carlson

& Sroufe, 1995; Cassidy & Shaver, 1999). Attachment status reflects the balance between a child's willingness to explore, and the need to stay close to a mother/caregiver following a short separation from her (see Ainsworth, Blehar, Waters, & Wall, 1978). Research with normative populations has demonstrated that between 50% and 70% of 12-to-18-month-olds are securely attached (Campos, Barrett, Lamb, Goldsmith, & Stenberg, 1983). The attachment behavior of infants who are not securely attached can generally be classified into one of three categories of insecure attachment: anxious-avoidant, anxious-resistant, and disorganized (acting in an odd and inconsistent manner). Estimates of secure attachment among high-risk samples (i.e., those exposed to several risk factors, such as poverty, violence, and/or abuse) vary, but are generally significantly lower than those found in the general population. In particular, maltreated children have disproportionately higher rates of disorganized attachment. For example, Egeland and Sroufe (1981) found fewer than 40% of young children in a maltreatment sample to be securely attached, and Cicchetti and Tucker (1994) found only 20% of young children in a maltreatment sample to be securely attached. The development of secure attachments is a key task of the infant, toddler, and preschool periods, and insecure attachment is a risk factor for later emotional and behavioral problems (Egeland & Erickson, 1993).

How might domestic violence exposure uniquely affect young children? Very little research has investigated attachment among infants and young children exposed to domestic violence, or the impact of domestic violence on attachment relationships. However, initial research has suggested that domestic violence might jeopardize the development or maintenance of such attachments (Zeanah et al., 1999). For example, Sims, Hans, and Cox (1996) found that when fathers were physically violent with mothers, infants were more likely to be insecurely attached to their mothers.

Young children, because of their dependence, are particularly vulnerable to threats aimed at their mother, particularly when the source of those threats is another caregiver—father or boyfriend—and most especially when the children themselves are a target of such threats. Earlier research with children exposed to community violence demonstrated that children's responses in times of threat may be mediated by the responses of their caregivers (e.g., Richters & Martinez, 1993). In particular, the level of stress experienced by the primary caregiver may affect the level of stress exhibited by the young child. However, recent reviews of the research on battered mothers reveal a less than clear relationship between the mother's stress and that of the child (see Edleson, Mbilinyi, & Shetty, 2003).

Research with young children and their mothers has demonstrated that early intervention can be successful in promoting healthy attachment relationships (Egeland, Weinfield, Bosquet, & Cheng, 2000). In particular, focusing on promoting healthy relationships and sensitive and responsive parenting, combined with concrete support to help vulnerable mothers access needed services and develop strong social support networks, has been shown to be effective in increasing relationship functioning and mothers' enjoyment of their children. Programs focused on working with mother-infant/young child dyads who face multiple risk factors, such as poverty, teen parenting,

and exposure to violence, have been validated with families from different cultures (Egeland & Erickson, 1993).

Further research is needed not only to look at the effects of exposure to violence on mother-infant attachment, but also the direct and indirect effects of abusive men and fathers on the development of infant-mother attachment relationships. Insofar as the behavior of the abusive male disrupts the child's and mother's sense of safety and security, and creates fright in addition to physical injury, the abuser may play a key role in the disruption of an attachment relationship. Disruptions to attachment relationships among children exposed to domestic violence may not, however, occur only as a result of the violence, but may also be the result of multiple stressors in a child's environment (such as poverty, homelessness, and separation from a caregiver).

Longitudinal studies (e.g., Egeland & Sroufe, 1981; Egeland, Carlson, & Sroufe, 1993) have shown that attachment status can change over time, with changes in environment. Some studies following battered women and their children (Holden, Stein, Ritchie, Harris, & Jouriles, 1998; Wolfe, Zak, Wilson, & Jaffe, 1986) have documented improved parent-child relationships and/or child adjustment following cessation of domestic violence and increased stability of living conditions. Walker (1984) interviewed battered women who reported using less violence with their children as they moved further away from being victims of violence themselves. It is possible that attachment relationships between mothers and children may show improvement as a result of the cessation of the abuse.

The development of a secure attachment relationship in infancy provides a solid foundation for the development of self-regulation in early childhood: when a caregiver meets and responds to her infant's needs, the secure child eventually learns internal self-regulation.

Self-Regulation

As a toddler enters her second and third years, a key set of challenges includes learning to modulate affective, behavioral, and cognitive displays through internal control (Cicchetti & Tucker, 1994; Marans & Adelman, 1997). The development of self-regulation across various domains of functioning is influenced by both a child's temperament and experiences. A child is both influenced by and influences his or her own experiences, resulting in further modification of internal systems such as self-regulation (Cicchetti & Tucker, 1994). The development of self-regulation is a prerequisite to the development of social skills that allow individuals to successfully negotiate complex social situations and to develop reciprocity and empathy, i.e., connections with others. For example, the development of attentional skills enables a child to focus on tasks and peer situations and to persist at challenges, while impaired self-regulation has been associated with conduct and behavior problems (Masten & Coatsworth, 1998). These problems are particularly detrimental during the preschool to school-aged years, when adherence to rules and prosocial behavior is emphasized.

While there is no research on this topic related to domestic violence exposure, it may be that exposure to physical violence by a father, or by a boyfriend of the child's mother, provides a

model of behavior that lacks regulation of negative emotions. In the subset of children who also experience direct abuse at the hands of a caregiver, this modeled lack of regulation may be even more apparent. While exposure to risk factors can negatively affect the development of self-regulation, early efforts that successfully target the self-regulatory system may have lasting protective effects. Examples of such efforts include enriched childcare and preschool programs, with curricula that focus on successful regulation of anger and negative emotions in young children as a precursor to the development of social and conflict resolution skills. In addition, home-based programs that enhance parenting skills offer techniques for modeling self-regulation by working with parents and children simultaneously.

Social and Peer Competence

As infants become toddlers and preschoolers, awareness of the outside world increases, coupled with the development of more sophisticated communication skills (Bloom, 1991). Key tasks that help prepare the young child for kindergarten include the development of language and communication skills that ready a child for entry into a group situation; the negotiation of social situations, including conflict situations; and adherence to rule-governed social behavior. Social competence is a key task of the preschool to school-aged period, and high social competence has been associated with better behavioral control and increased sociability and agreeability (Rothbart & Bates, 1998).

Socialization and the development of social competence begin in infancy, when babies learn that their social reactions (gaze, smiles, sounds) are responded to by caregivers via a process of "reciprocal matching" (e.g., Oden, 1987). As children grow, parents, peers and extended kin support socialization. Peer contexts are one of the primary sources of social (as well as cognitive) development, especially for the development of empathy and role-taking (Piaget, 1932). Social development may be hampered by societal factors such as poverty and social isolation that may leave young children with fewer opportunities for interaction (Oden, 1987). On the other hand, offering parents an opportunity to develop support networks, including those that offer children increased opportunities for socialization, can be beneficial to social development.

There is little research on the social and peer development of young children exposed to domestic violence. Some studies have indicated that exposed children demonstrate lower social competence than do other children (e.g., Fantuzzo et al., 1991). Rossman (2001) suggests that young children exposed to violence may try to protect themselves more than other children by decreasing the attention they give to new information, becoming highly vigilant, and possibly distorting information when it contains socially aggressive content.

Evidence from research with maltreated children (Dodge, Pettit, Bates, & Valente, 1995) and children exposed to community violence (Schwartz & Proctor, 2000) does suggest a hypervigilant processing pattern. Among maltreated children, repeated victimization by parents may alter children's representations of relationships in a way that makes them hypervigilant to signs of threat in other social contexts (Dodge et al., 1995). This hypervigilant processing pattern, though

adaptive in actual threat situations, might serve to fuel aggressive and hostile reactions in peer interactions, leading to negative feedback from peers that in turn serves to crystallize aggressive dispositions (Dodge et al., 1995). There is not yet any empirical evidence that such processes occur in children exposed to domestic violence.

Despite the lack of research focused on children exposed to domestic violence, one could conclude that the development of secure attachments, self-regulation, and social competence might be disrupted in the context of ongoing domestic violence, negatively influencing the way in which a child approaches interpersonal relationships and the common tasks of childhood. The degree of exposure to domestic violence, as well as other risk factors (such as poverty) and the influence of protective processes (e.g., the amount of social support, and the extent to which mothers are able to buffer young children from exposure to violence), are key variables that might affect the relationship between children's exposure to violence and poor developmental outcomes. Efforts to enhance a battered mother's social support network, including those providing direct opportunities for children to spend time in positive social contexts, and those focused on encouraging secure attachments, all represent opportunities for enhancing the positive development of young children exposed to domestic violence and other risk factors such as poverty.

The Risk of Violence in Young Children's Lives

Violence in children's lives occurs within the context of the developmental tasks they must negotiate, as described above. Experiences of violent events vary greatly by child and include multiple risks as described below.

The Risk of Maltreatment and Domestic Violence Exposure

Early childhood has been identified as a point of great risk for some children. According to the Children's Bureau, children ages 0 to 3 years are the most frequent victims of reported child maltreatment, with 13.9 reported maltreated per 1,000 children (Children's Bureau, 1999). The Bureau also notes that maltreatment decreases as age increases. In a recent study of childhood homicides, Finkelhor and Ormrod (2001) noted that most young children who are victims of homicide are murdered at home, through beatings or suffocation. In contrast, older children and youth die increasingly at the hands of peers.

A number of reviews currently exist on the co-occurrence of documented child maltreatment and adult domestic violence. Over 30 studies of the link between these two forms of violence show a 41% median co-occurrence of child maltreatment and adult domestic violence in families studied (Appel & Holden, 1998), with a wide range of findings depending on the samples examined (Edleson, 1999b). Children are not only direct victims of assault; they are also frequently present when adult domestic violence is committed. In a recent study, Edleson, Mbilinyi, Beeman, and Hagemeister (2003) found that 45% of the 111 mothers they anonymously interviewed reported their children came into the room where abuse was occurring at least occasionally, while 18%

reported that their children frequently came into the room, and 23% reported their children never came into the room.

At least one study has looked at age differences among children's exposure to domestic violence and found that younger children are more likely to be exposed than others. Fantuzzo and colleagues (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997) reanalyzed data from the National Institute of Justice's Spouse Assault Replication Program (SARP). Examining data on police and victim reports of domestic assault incidents in five cities, they found that in all five cities studied, children ages 0 to 5 years were significantly more likely to be present during single and recurring domestic violence incidents.

Children's Responses During Violent Events

The fact that child maltreatment and adult domestic violence co-occur, and that children are present during assaults on a parent, is more clearly established than what children do when confronted with this adversity. Their responses have been shown to vary from becoming actively involved in the conflict, to distracting themselves and their parents, or distancing themselves (Margolin, 1998). Their responses also appear to vary both by gender and age. For example, Garcia O'Hearn, Margolin, and John (1997) studied 110 families and found that parents whose conflict was often characterized by physical violence as compared with other parents, reported that their boys (though not girls) were significantly more likely to respond to conflict by leaving the room or appearing sad or frightened.

Children of different ages show some variation in their responses to violent conflict at home. In one of the earliest studies on this subject, Cummings, Zahn-Waxler, and Radke-Yarrow (1981) examined mothers' reports of the responses of 24 children between the ages of 1 and 2 ½ years. They found that even children this young responded to angry conflict—conflict that included physical attacks—with negative emotions such as crying and with efforts to become actively involved in the conflicts. In a later study, Cummings, Pellegrini, Notarius, and Cummings (1989) found that as children aged, they showed increasing evidence of a variety of responses. Forty-eight children between the ages of 2 and 6 were studied and, as they got older, they increasingly observed the conflict, expressed concern, sought social support, and intervened to protect or comfort their mothers. This effect was greater among children whose parents were engaged in physical conflict when compared to others, and among boys when compared to girls. As far as we know, no research has investigated cultural differences among children's responses in the wake of domestic violence.

The Impact of Domestic Violence Exposure

The past few decades have seen a significant increase in research on the impact of children's exposure to many different forms of violence and family conflict. These studies include exposure to media-based violence (Griffiths, 1999; Paik & Comstock, 1994), school and community violence (Horn & Trickett, 1998), and non-violent marital conflict (Emery, 1982; Grych &

Fincham, 1990). It is clear from this research that children are exposed to and affected by a wide range of violence and conflict in their social environments, from multiple murders on television or in video games to fights in schools, on the street, or in their homes.

Almost 100 published studies report associations between exposure to adult domestic violence and current child problems or later adult problems. Only about one third of these studies have separated exposed children from those who were also direct victims of abuse, allowing one to determine the unique impact on children of exposure separate from direct abuse. Few have examined how exposure differentially affects children of various ages.

A number of authors have produced partial reviews of this growing body of literature and its limitations (see Edleson, 1999a; Fantuzzo & Mohr, 1999; Holtzworth-Munroe, Smutzler, & Sandin, 1997; Margolin, 1998; Peled & Davis, 1995; Rossman, 2001). Overall, existing studies reveal that some children exposed to adult domestic violence exhibit more difficulties than their non-exposed peers in areas of social, emotional, and behavioral functioning. However, a recent meta-analysis reported that 40 out of 41 studies demonstrated significant associations between exposure to adult domestic violence and child behavior and emotional problems (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003).

Children exposed to violence, on average, exhibit more aggressive and antisocial behaviors ("externalizing" behaviors) as well as fearful and inhibited behaviors ("internalizing" behaviors) when compared to non-exposed children (Fantuzzo et al., 1991; Holden et al., 1998; Hughes, 1988; Hughes, Parkinson, & Vargo, 1989). Exposed children also were found to show higher average anxiety, depression, trauma symptoms, and temperament problems than children who were not exposed to violence at home (Hughes, 1988; Maker, Kemmelmeier, & Peterson, 1998; Sternberg et al., 1993).

Given the different tasks that each developmental stage requires, it would seem that domestic violence would differentially impact children at different ages. As noted earlier, few studies have examined the impact of violence on functioning in a developmental context. One study did find that younger children exhibited significantly greater problems than older children. Hughes (1988) compared children who were exposed to domestic violence (n=40), both exposed and themselves abused (n=55), and a comparison group that was neither exposed nor abused (n=83). The ages of the children ranged from 3 to 12 years. Hughes analyzed data for groups of children who were young (3-5 years), middle age (6-8 years) and older (9-12 years). She found significant differences in child problems based on the age of the child. Between groups, she found that the youngest children who were both exposed to domestic violence and also victims of abuse showed significantly more problems than younger children in the other two groups. Within the abused and exposed group, young children also showed significantly more problems than either middle-school-age or older children in the same group. Hinchey and Gavelek (1982) found preschoolers of battered women to be less empathic than children not exposed to violence. Graham-Bermann and Levendosky (1998) found preschoolers exposed to domestic violence to be more likely to

express negative affect; to call other children names or insult them; and to bite, hit, or slap their peers during play interactions.

In general, research has demonstrated that exposure to domestic violence may represent a significant risk factor for the healthy development of young children. Although cross-sectional studies of the kinds described above are valuable in demonstrating associations with different aspects of functioning and in documenting the ways in which children are affected by domestic violence in the short-term, they tell us little about the impacts on development over the longer-term. Longitudinal studies of other at-risk populations have illustrated the ways in which various types of risk factors may adversely affect children's developmental trajectories, and the ways in which protective factors serve to help children get "back on track" despite exposure to risks. In one of the few existing longitudinal studies that incorporated child exposure to adult domestic violence as a variable, Yates, Dodds, Sroufe and England (2003) found that (controlling for abuse, life stress, socioeconomic status, and cognitive ability) witnessing domestic violence in the preschool years was related to behavior problems at age 16 for both sexes; for boys, middle childhood exposure was related to contemporaneous behavior problems. This study looked at data from a prospective, longitudinal study of high-risk families. There is a significant need for prospective longitudinal studies looking primarily at the developmental sequelae of exposure to domestic violence in childhood.

The Effects of Adversity on Development

One of the findings from existing longitudinal studies of children is that adversity may accumulate over time. In the subsections below, we examine some of the findings on cumulative risk, how these might relate to the literature on domestic violence exposure, and the possible impact on brain development that multiple adverse events may create.

Studies of Cumulative Risk

There is a significant body of longitudinal research indicating how exposure to multiple risk factors is harmful to children's development. For example, Rutter (1985, 1987) identified six familial variables that proved to be significantly associated with poor adaptive outcomes in children. These included severe marital discord, low socio-economic levels, overcrowding or large family size, paternal antisocial disorder, maternal psychopathology, and removal of the child from the home. The presence of two risk factors increased the probability of problems fourfold; those children with four or more risk factors showed a 21% chance of exhibiting diagnosed disorders, as opposed to 6% in children experiencing two or three. Sameroff and Seifer (1990) studied the effects of cumulative risk on children of schizophrenic mothers. Each of the 10 familial factors studied was estimated to cost the child the equivalent of four IQ points at age 4, compared to the development of other children. The effects of the cumulative risk factors led to decreases in competencies necessary for success later in life. Follow-up at age 13 indicated that the longer the continuation and the larger the accumulation of risk factors, the greater the negative influence on the child's cognitive and social-emotional development. Similarly, Masten and Sesma (1999)

found that as the number of risk factors present in a homeless child's life increased, the level of negative outcomes (e.g., problem behaviors and hunger) increased accordingly. As noted above, poverty is a significant risk factor for poor outcomes in children. Research on the impact of minority status and race on children's development and adjustment has largely been confounded by failing to control for socioeconomic variables, and it therefore tends to perpetuate negative stereotypes (Graham, 1992). The few studies that have investigated the effects of race on development, and have also taken into account socioeconomic factors, have shown that the effects of race contribute far less to children's behavior problems and adjustment than socioeconomic status (e.g., Patterson, Kupersmidt, & Vaden, 1990; Stevenson, Chen, & Uttal, 1990).

Cumulative Risk in the Case of Domestic Violence

A number of factors have been found to be associated with the degree to which a child is affected by violence exposure. For example, whether or not a child is also a direct victim of abuse seems to be associated with the degree of harm experienced. Hughes et al. (1989) found that children who were both abused and exposed exhibited the most severe problem behaviors, a witness-only group showed moderate problem symptoms, and a comparison, no-exposure group showed the least symptoms. This same pattern appears in a series of other comparison group and correlational studies (see Carlson, 1991; Hughes, 1988; O'Keefe, 1994; and Sternberg et al., 1993). Children seem to agree; for example, in one study the children indicated that being abused, or both abused and exposed, had a greater negative impact—based on their self-ratings of problems—than did witnessing adult domestic violence alone (McClosky, Figueredo, & Koss, 1995).

Gender appears to be another factor that affects the types of problems experienced. In general, boys have been shown to exhibit more frequent problems, especially those categorized as externally oriented, such as hostility and aggression, while girls generally show evidence of more internally oriented problems, such as depression and somatic complaints (Carlson, 1991; Stagg, Wills & Howell, 1989). There are also findings that dissent from this general trend by showing that girls, especially as they get older, may also exhibit aggressive behaviors (for example, Spaccarelli, Sandler, & Roosa, 1994).

Other risk factors that detrimentally affect children are often closely associated with exposure to domestic violence and poverty. These may include shelter placement, school disruptions, or separation from extended kin. For example, in their study of homeless children, Masten and Sesma (1999) found that 40% of mothers revealed domestic violence to be a major cause of their homelessness. In general, among these children, exposure to further risk factors—such as domestic violence in addition to homelessness—was associated with poorer functioning on school-based cognitive tasks.

Finally, a number of authors have discussed the mother-child relationship and parental functioning as key factors that may mediate or moderate the impact of violence on children's functioning. Some have conjectured that a mother's poor mental health would negatively affect a child's experience of violence, but the data are conflicting. Levendosky and Graham-Bermann

(1998) found that the children of mothers exhibiting stress showed more problem behaviors themselves. Holden and Ritchie (1991) also found that as maternal stress increased, so did children's problems. On the other hand, McClosky et al. (1995) found that a mother's poor mental health did not affect her child's response to violence in the home.

One apparent problem in the few studies that have examined parent-child relationship factors is an over-reliance on measures of the mother-child relationship, while little data exist about father-child relationships in these families (Sternberg, 1997). In one of the few studies on father-child relationships and domestic violence, Sullivan, Juras, Bybee, Nguyen, and Allen (2000) found that the relationship of an abusive male to the child directly affected the child's well-being, without being additionally affected by the mother's level of mental health. In particular, step-fathers in their sample seemed to be more emotionally abusive to the children, and children's fear of step-fathers was greater than fear of biological fathers or unrelated male partners in the home.

The research on cumulative risk factors affecting children exposed to domestic violence remains inconclusive. There is a need for more research aimed at understanding the specific effects of exposure to violence on young children, how violence-related risk factors interact with each other, and how they affect a child's development over time.

The Developing Brain

There is growing interest in understanding the cumulative impact of a child's traumatic experiences on brain development. The first several years of life are crucial for the development of the prefrontal cortex, which is implicated in many of the advanced or "executive" functions that humans perform—e.g., inhibition of impulsivity, planning and execution of complex tasks, and behavioral and emotional control (e.g., Thompson & Nelson, 2001). Research indicates that experiences in early childhood seem to influence how the brain processes later experiences (e.g., Gunnar & Barr, 1998). For example, studies of children exposed to severe adversity, including abuse and neglect, have demonstrated brain and self-regulatory deficits in basic functions such as the regulation of sleep-wake cycles and the control over stress responses (Gunnar & Barr, 1998; Nelson & Carver, 1998). In particular, the impact of early activation of the hormonal stress systems via early traumatic experiences may have lasting effects on the regulation of these systems. Although much remains to be learned about stress in humans, evidence indicates that children who regularly produce higher levels of cortisol (the primary stress hormone in humans) show more difficulties in sustaining attention than do those with lower cortisol levels, as well as compromised self-control and behavioral inhibition, and memory deficits (Gunnar, Tout, de Haan, Pierce, & Stanbury, 1997).

Research has demonstrated that secure attachment relationships, high quality parenting, and the expectations about competence and control gained in the context of a secure caregiver-infant relationship may serve as protective factors for young children (Ainsworth & Bell, 1973; Mineka, Gunnar, & Champoux, 1986; Nachmias, Gunnar, Mangelsdorf, Parritz, & Buss, 1996). Conversely, insecurely attached toddlers show elevated cortisol levels to even mild stressors such as

brief separations or strange encounters, and those with a history of abuse and neglect seem to be at greatest risk for stress reactions (Hertsgaard, Gunnar, Erickson, & Nachmias, 1995; Spangler & Grossman, 1993). However, despite important findings about early brain development, the specific effects of exposure to domestic violence on early brain development remain untested hypotheses.

Nonetheless, research does suggest that repairing early damage to the stress apparatus is possible (Meaney et al., 1996; Mineka et al., 1986). Ensuring that interventions attempt to help children gain control over their environments is important, since one of the hallmarks of children's experiences with domestic violence is a lack of control over the environment. In addition, supporting battered mothers in their efforts to develop and maintain predictable and safe life routines—insofar as is possible—is consistent with both research and effective interventions with high-risk children and families.

Resilience

In the face of significant adversity and cumulative risk, some children develop successfully, performing at least as well as their low-risk peers across a variety of domains (Garmezy, 1974; Garmezy & Masten, 1994; Werner & Smith, 1992). These children have been labeled competent, resilient, and even invulnerable (Anthony & Kohler, 1987). What factors enable such children to overcome adversity? Masten (2001) has used the term "ordinary magic" to describe competence in the face of adversity, suggesting that resilience among high-risk children is not as rare as once thought. Studies (e.g., Garmezy & Masten, 1994; Werner & Smith, 1992) have elicited several core characteristics of resilient children and their environments—among them competent parenting and healthy attachment relationships, intellectual resources, social competence, and easy temperament.

Studies of Resilience

Resilience is increasingly described as a pattern (Masten, 2001), a dynamic developmental process (Egeland et al., 1993) or a developmental progression in which new strengths and vulnerabilities emerge over time and changing circumstances (Luthar, Cicchetti, & Becker, 2000). From earlier research that focused on identifying protective factors associated with resilient functioning, researchers are increasingly interested in understanding protective processes, or the mechanisms through which protective factors operate (Luthar et al.). Hence, while some children's functioning may become very compromised during stressful circumstances (e.g., while witnessing violence, and while leaving home for a shelter) they may recover quickly to developmentally-appropriate functioning when they return, with their mothers, to permanent, safe, living arrangements.

Drawing from longitudinal data on high-risk children, Masten and colleagues (e.g., Masten & Reed, 2002; Masten & Sesma,1999) have demonstrated a positive relationship between the level of adversity to which children are exposed, and the likelihood of negative outcomes. In the reverse, Masten and Reed (2002) have proposed that as assets in a child's environment increase,

the problems she experiences may decrease. For example, Diener, Nievar, and Wright (2003) found that greater cumulative assets were related to more secure attachment relationships in a sample of mother-young child dyads. This supports the notion that minimizing the number of risk factors to which children are exposed, while simultaneously encouraging protective processes, can be highly effective in reducing negative outcomes.

Resilience Among Children Exposed to Domestic Violence

There is limited research on how children cope with exposure to domestic violence, despite the fact that at least three recent studies have shown variability in children's experiences. For example, a study of 58 children living in a shelter and recently exposed to domestic violence found great variability in problem symptoms exhibited by the children (Hughes & Luke, 1998). Over half the children in the study were classified as either "doing well" or "hanging in there." Children "hanging in there" were found to exhibit average levels of problems and of self-esteem and some mild anxiety symptoms. The remaining children in the study did show problems: 9 showed "high behavior problems," another 9 "high general distress," and 4 were labeled "depressed kids." In a more recent study, Grych, Jouriles, Swank, McDonald, and Norwood (2000) found that of 228 shelter resident children, 71 exhibited no problems, another 40 showed only mild distress symptoms, 47 exhibited externalized problems, and 70 were classified as multi-problem. Finally, Sullivan, Nguyen, Allen, Bybee, and Juras (2000) studied 80 7-to-11-year-old children of 80 mothers with a recent history of domestic violence. The children reported themselves to be happy with themselves (83%), liking their physical appearance (83%), and feeling they often do the right thing (73%). Their mothers also reported their children to be relatively healthy on a behavioral checklist. It appears that at least half the children in these studies were surviving the experience with few or no problems evident.

How does one explain these findings? On the one hand, it may be that our measures are just not sensitive enough to observe the entire range of harm done to these children through exposure to violence. It may also be that we have not followed children long enough to determine the true impact of violence exposure. On the other hand, it is also highly likely that children's experiences vary greatly in a number of ways. Holden et al. (1998) have proposed that the seeming variations in functioning exhibited by children of battered women might be accounted for by three key factors: the extent of the violence, the child's characteristics, and parenting factors. With regard to the extent of the violence, we know that the level of violence in each family is different (Straus & Gelles, 1990). In addition, a number of studies have revealed that each child's exposure to or involvement in violent events varies considerably. Finally, the protective and risk factors in a child's life may vary a great deal (Hughes, Graham-Bermann, & Gruber, 2001; Masten & Coatsworth, 1998).

At present, we have little systematic data on what risk and protective factors are most important for the healthy development of children exposed to domestic violence, and we can only speculate about the relative importance of these factors.

Implications for Research, Practice, and Policy

How does research on risk and resilience among high-risk children aid us in ameliorating the impact of exposure to domestic violence on young children living in poverty? Children and families can best be helped through a continuum of supports, from naturally-occurring supports within the family and the community (such as kinship networks and neighborhood groups) to more intensive interventions offered by battered women's advocates or social service and mental health agencies. Children's and families' needs vary widely, not only because of differing individual and family risk and protective factors, but also because of differences in race, ethnicity, cultural, and community factors.

From the viewpoint of a resilience framework, efforts that target the major developmental tasks of early childhood, as well as those that directly reduce the impact of the stressors faced by children exposed to domestic violence (e.g., violence, homelessness, poverty, loss or separation from caregivers) should be effective in helping young children negotiate developmental challenges. Masten and Coatsworth (1998) propose that such strategies fall into three major categories: (a) risk-focused (focusing on reducing or preventing risk and its impact), (b) resource-focused (adding resources to counterbalance risk) and (c) process-focused (strategies that focus on the processes underlying competence, such as parent-child relationships, social skills, and self-regulation) (Masten & Coatsworth, 1998). Examples of risk-focused strategies might include legal strategies such as more stringent sentences and mandatory arrest policies to deter offenders, or safety planning with battered women and their children. Supporting battered women and children to develop social support networks might be an example of a resource-focused strategy aimed at decreasing the isolation associated with domestic violence. Process-focused strategies might include social development curricula in preschools, or relationship-based interventions with battered mothers and their children to help repair the damage violence has wrought (with the latter aimed at enhancing attachment and effective parenting).

Intervening to support young children exposed to domestic violence requires a consideration of the larger context within which the child resides. Hence, efforts that directly target the impact of exposure to domestic violence will be most helpful if they occur in conjunction with those that help promote children's competence in a variety of domains within the family, community, and cultural contexts. Linking a family with supportive resources that have proven effective with vulnerable children may provide additional protective assets and lessen risk factors. Supportive interventions are likely to be most effective when mothers and children voluntarily participate in them rather than being mandated into them (and seeing service providers as part of the "system" that threatens their parental rights).

For young children exposed to domestic violence, strategies might include general early childhood programs (targeting multiple skill domains in young children and families living in poverty) and/or services specifically targeted to children exposed to domestic violence. Early childhood programs include Early Head Start/Head Start (or similar, empirically-validated programs that

combine high-quality child care with home-based support for caregivers), home visitation programs, and dyadic interventions that focus on mother-infant attachment.

Head Start has a core educational component that offers the child structured social skills development and educational opportunities outside the home, with additional family support activities, including home-based interventions. Effective home visitation programs offer mothers support and guidance with healthcare, nutrition, housing, and other "concrete" issues, and emotional support with the tasks of parenting under stress. Additionally, programs that focus on promoting healthy attachment relationships between young children and their non-abusive caregivers can help support mothers to transform the potentially damaging effects of domestic violence on attachment relationships.

These child-focused and family-centered strategies have been validated with children who live in poor, often ethnically diverse, families. Home visiting programs have been found to be less successful for families experiencing high levels of domestic violence (Eckenrode et al., 2000; Duggan et al., 1999), possibly because staff implementing these interventions were not trained specifically in understanding and supporting the unique needs of families in which domestic violence was occurring. If such interventions are to be successful with these families, program structure may need to be changed to be more responsive to the effects of domestic violence.

Many battered women's shelters and community-based domestic violence programs have long provided services to children who have witnessed violence. These services are often in the form of small groups for children (see Graham-Bermann & Edleson, 2001; Peled & Davis, 1995; Peled, Jaffe, & Edleson, 1995). Several other community-based programs providing trauma treatment and social support also serve exposed children and their families. For example, the Child Witness to Violence Project (CWVP) at Boston Medical Center was founded in 1992 with the goal of providing therapy services for children who had been exposed to various forms of violence in the community. About two thirds of the children referred for services had been exposed to domestic violence (Groves & Zuckerman, 1997). The CWVP now provides services for children to heal from the trauma of violence exposure and for parents to help their children, works closely with domestic violence and other community agencies to help families find safety, and offers intensive training for a variety of professionals (see Groves, Roberts, & Weinreb, 2000).

The programs described above are but one way of supporting battered mothers and their families. There are many other ways to do so, including domestic violence advocacy aimed at empowering and supporting battered women, and legal interventions aimed at holding the batterer accountable for his behavior. Protecting and supporting women through effective advocacy helps to protect and support children (Sullivan & Bybee, 1999) and should focus on providing tangible assets for families to meet basic needs and minimize risks to the child. For any intervention to be successful, it must attend to the family's economic and cultural context and needs, and build on the natural supports around the child and family.

Unfortunately, our thinking about these issues occurs in a research vacuum. At present there are a) few standardized measures for understanding or assessing the impact of violence exposure on young children, b) few program evaluations on the impact of early childhood supports for children who have experienced domestic violence and for their families, and c) very few longitudinal studies to help us understand the interaction of these events over time.

There are many relevant research questions embedded within each of these research domains. For example, how can we best assess a child's situation, and the risk and protective factors present in his or her life? How are the basic developmental tasks of childhood affected by exposure to violence, and how does such exposure interact over time with other, multiple risk and protective factors in a child's life? How can home visitation or other early support efforts be altered to become more effective in families where domestic violence is occurring? These and many similar questions await future studies aimed at developing more effective responses to these children and their families.

Although research has elucidated many of the key individual and family risk and protective factors that are important influences in development, research that investigates ethnic, cultural, and community contextual risk and protective factors lags behind. In addition, understanding the specific risk and protective factors for children exposed to domestic violence is critical to the development of effective prevention and intervention programs that disrupt the cycle of violence for children and their mothers. Findings also consistently show that poverty is the single most significant threat to school readiness for high-risk children: while early cognitive and language skills are important to school readiness, self-regulatory skills, and social and peer competence, are arguably even more important skills for success in school and beyond.

Conclusion

Early support and intervention efforts provide important avenues through which young children exposed to domestic violence may be able to access the services needed to bolster their developmental trajectories and minimize the risks to which they are exposed. As research findings and program evaluations improve our ability to support children exposed to domestic violence, a key location of these change efforts must be in programs aimed at young children. These programs vary: some provide emotional support to children and mothers aimed at specifically addressing domestic violence issues, while others offer interventions to enhance development in the developmental domains described above. The common theme across these programs is that they provide children and their families with resources to support the tasks of development. For toddlers and preschoolers, both home-based and childcare/preschool-based programs should focus on the enhancement of self-regulatory skills and of social and peer group competence. Finally, programs should aim to support secure attachments between young children and their non-abusive mothers and must focus on enhancing safety and stability for children and their parents.

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