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HELPING CHILDREN AFFECTED BY DOMESTIC VIOLENCE

A report from the conference held on September 30, 2004 at the Washington State Criminal Justice Training Commission, Burien, WA

The purpose of this conference was to:

- Present a review of research and policy related to children affected by domestic violence (DV)
- Present risk factors and protective factors influencing the impact of DV on children
- Present effective methods to assess DV with children and their caregivers
- Discuss effective intervention approaches for children
- Discuss strategies for supporting DV victims with parenting concerns and for providing emotional support to their children

Setting the Stage

Jeff Norman, Program Manager, Region 4, Division of Children and Family Services (DCFS), moderated the day's events. Opening remarks were offered by Washington State Supreme Court Justice **Bobbe Bridge**; DCFS Region 4 Administrator **Jackie Buchanan**; and **Dr. Michael Parsons**, Executive Director of the Washington State Criminal Justice Training Commission.

Justice Bridge noted that domestic violence is often cited by Child Protective Services as the primary reason for removing a child from the home. She asked, "How can the victims of domestic violence be protected? What should Child Protective Services do when a batterer returns home?" She cautioned that agencies and courts may sometimes make things worse "when our own passions get in the way of someone else's efforts to make an impact on a violent situation." The common goal is to protect domestic violence victims and their children.

ABOUT THE CONFERENCE:

Helping Children Affected by Domestic Violence was convened by the King County Women's Programs (DV/CPS Collaboration Project); the Washington State Criminal Justice Training Commission; the South King County Community Network; the Greater Pierce County Community Network; Region Four Division of Children and Family Services; Public Health – Seattle & King County; the Human Services Policy Center, Evans School of Public Affairs, University of Washington; the Snoqualmie Valley Community Network; the Greater Issaquah Youth and Family Network; the University of Washington School of Social Work; Northwest Institute for Children and Families; and the American Professional Society on the Abuse of Children. Approximately 500 people attended, representing a broad spectrum of social services, health, judicial, governmental, research, law enforcement, and advocacy organizations.

Bridge described a multidisciplinary project that started in 2002 and has led to the development of a protocol to guide decisions concerning children exposed to domestic violence. Six DSHS regions came together to develop components of basic protocol that should guide agency actions in all six regions.

The following components are included in the state's interagency domestic violence protocol:

- Whenever possible, children should remain in the care of the victimized parent, not with offending parent.
- Children function best if they remain safely in their families.
- Each agency will provide individualized services for families.
- Agencies will support or develop techniques that are responsive and relevant to the needs and values of different cultural groups.
- Agencies will implement policies based on best principles.
- Agencies will work together to ensure that assistance is timely.
- Agencies should share information, under conditions that would protect confidentiality and assure safety of children and victims.
- Cross training should be implemented in all communities.
- Agencies will gather information about strategies that have been used in the past with a particular family, and will record impacts on children.
- Workers will consult the Domestic Violence Database when making decisions.

PARTICIPANTS

Justice Bobbe Bridge, Washington State Supreme Court

Jackie Buchanan, Regional Administrator, Region 4, Division of Children and Family Services

Jeffrey Edleson, PhD, Professor, University of Minnesota School of Social Work; Director, Minnesota Center Against Violence and Abuse

Betsy McAlister Groves, MSW, LICSW, Founding Director, Child Witness to Violence Project, Boston Medical Center; Assistant Clinical Professor of Pediatrics, Boston University School of Medicine

Jeff Norman, Program Manager, Region 4, Division of Children and Family Services

Michael Parsons, PhD, Executive Director, Washington State Criminal Justice Training Commission

This multidisciplinary training event highlighted the cross-system dialogue necessary for creating a more effective system for dealing with DV cases. The goal of the training was to improve processes, delivery service more efficiently, and save more lives.

Dr. Jeffrey Edleson, Director of the University of Minnesota's Domestic Violence in the Lives of Children, laid the empirical groundwork for **Betsy McAlister Groves'** clinical training sessions with his presentation, "Domestic Violence in the Lives of

Children: Research and Policy." Copies of both presenters' PowerPoint slides, which are summarized here, were included in the conference handouts.

Domestic Violence in the Lives of Children: Research and Policy

Edleson's well-documented presentation began with a reminder that, although most people think that 100 percent of the victims of domestic violence are women, half of the residents of battered women's shelters are children. The presentation was occasionally illustrated with drawings by children, showing how they were affected by their exposure to domestic violence (for drawings, go to http://www.mincava.umn.edu/documents/drawings/drawings.html). Several of the drawings depicted scary phenomena – such as volcanoes and lightning – that are overwhelming and out of a child's control. An important take-home point from the drawings was that when children equate anger with violence, they start to see violence as an appropriate response to anger.

Children are exposed to violence in the media, in the community, and at home. Children who make 911 calls are often afraid – of the violence itself and of being the person who reports that violence. Children are usually present during domestic violence. They see, hear, and are sometimes instructed to participate in violent acts. They are often threatened and many are either accidentally or intentionally injured. And children have to deal with the aftermath – seeing and sometimes caring for an injured parent and/or siblings; leaving home to go to a shelter; leaving pets behind. An estimated 7 to 14 million children are exposed to domestic violence each year.

In general, children exposed to domestic violence show behavioral and emotional problems, cognitive functioning problems, and longer-term problems, including adult depression and distress, trauma-related symptoms, low self-esteem, and difficulties with social adjustment. Clearly, violent behavior in the household does not provide a good model for social relations, and can interfere with a child forming secure attachments, learning self-regulation, and establishing healthy social and peer relations.

Researchers have found a significant degree of overlap between domestic violence (DV) and child abuse and neglect (CAN). Following up on this link, Edelson asked conference attendees to consider two questions: (1) Is child exposure to domestic violence a form of child maltreatment? (2) Who is responsible for this maltreatment? The general public, when asked these questions, has concluded:

- Exposure to violence harms and endangers all children.
- Mothers who stay with an abuser are not protecting their children.
- Childhood exposure to violence is a form of maltreatment.
- Child protective intervention is needed in these circumstances.

Edelson reviewed new child witness laws as they pertained to criminal charges/penalties and custody/visitation determination in several states. In general, new laws defining exposure as maltreatment tend to be underfunded, so child protective services are overwhelmed. In Minnesota, expanding the definition of neglect to include exposure to violence resulted in more screenings and investigations, but fewer services. In the "real world," new child witness laws have often created punitive systems that penalize the mother (victim) without necessarily implicating the perpetrator of violence.

Stepping back from a microscopic view of the data, Edelson stressed that the responses to family violence vary considerably. Many children who have been exposed to violence – even those in the same family – show no more problems than children without such exposure. Edelson recommends a continuum of care, with responses tailored to each child's resilience and degree of impairment. Edelson believes that the majority of children exposed to domestic violence should not be in the child protection system. He contrasted the reporting laws for domestic violence with those for other dangerous exposures such as corporal punishment, parental alcohol abuse, second-hand smoke, violent media and games, and school/neighborhood violence.

Mother's safety and children's safety are tightly linked, and women's strategies often focus on their children's well-being. A mother may stay in an abusive relationship for several reasons (fear of greater harm and lengthy custody battles; belief that the children need a father; financial support). Some of these same reasons (concern for children's safety and children's need of a parent) may also motivate a mother to leave the relationship. Leaving is usually a process involving multiple separations. Because this is a dynamic process, enhancing a mother's safety and stability is a major avenue for improving children's well-being. For some, child protective services (CPS) will be necessary, but many will never enter CPS; we should support a continuum of responses tailored to individual circumstances.

A national group of judges has compiled best practice guidelines and put them into "The Greenbook" (see http://www.thegreenbook.info/), a major initiative to help family courts work with child welfare and domestic violence agencies to help families experiencing violence.

Edelson recommends that communities and institutions collaborate in voluntary, community-based programs like the one that Betsy McAlister Groves and her colleagues have established in Boston. These programs should be guided by careful assessment of violence, exposure, and harm to children, and they should provide services that are sensitive to supporting mother and child safety simultaneously. The need for such services vastly outstrips capacity. Edelson suggests expansion of the capacity of first responders and community service providers as well as general expansion and reallocation of resources that serve children exposed to violence. Putting probation officers and child-protection

services workers in the same location could reduce costs and improve communication among those who work with families experiencing DV.

Betsy McAlister Groves, MSW, LICSW, social worker and assistant professor of pediatrics at Boston University, is founding director of Boston Medical Center's Child Witness to Violence Project. In 2002, she published the book, *Children Who See Too Much: Lessons from the Child Witness to Violence Program.* In her morning presentation McAlister Groves talked about the program – a voluntary, community-service organization. In the afternoon she talked more specifically about assessment and intervention.

Promising Practices for Children: Overview of the Child Witness to Violence Program

Since the program's inception in 1992, several changes have occurred, including:

- Increased recognition of domestic violence as a problem (the program was started because of the rising incidence of community violence in Boston)
- Increased social acceptance of women who disclose histories of abuse
- Increased funding for services
- Increase in research/studies of children affected by violence
- Changes in legislative and case law

In a study conducted at Boston Medical Center in the early 1990s, McAlister Groves and her colleagues interviewed 115 women to find out how children age 6 and older were affected by exposure to violence. They learned that one in 10 children had witnessed a knifing or shooting by the age of 6 (mean age of exposure was 2.7 years; 18% witnessed moderate violence; and half of the violence had occurred in the home.

The interdisciplinary, multilingual Child Witness to Violence Project provides child-centered, family-focused counseling to children, birth to age 8, who have been exposed to violence. Counseling is also offered to the children's caregivers, and training and consultation are provided to a wide range of professionals. These free services – primarily office-based – are offered to about 125 families per year, and involve individual treatment of the child, sessions with parent(s) and with parent and child together, and advocacy/case management (a critical part of the intervention). Referrals come from health systems, shelters, the courts/law enforcement, early childhood providers, Department of Social Services (DSS), and individuals. The program has greater success with self-referrals (women who are concerned that a child's problems may be related to events in the home) than court referrals.

The intervention can be conceptualized as a series of concentric circles with the child at the center, and moving out successively through the primary caregiver

and family to the immediate community (school, neighborhood, work, and peers), and then to the larger society. The main principles of intervention include:

- Establishing a safe therapeutic relationship with the family
- Responding as soon as possible after the violent event
- Understanding child development, the developmental impact of trauma, and domestic violence
- Including advocacy and case management as critical components
- Using multidisciplinary assessment

Most of the children are age 6 and younger. More than 40% are Latino and about 35% are African American.

In partnership with the Boston Police Department, Safe Havens Training Projects, and others, a number of special training and intervention projects are in progress.

Although the project has not yet undergone a long-term follow-up, several lessons have been learned to date:

- Being a bystander to violence may be as traumatic as being a direct victim. This is important knowledge, as judges want proof that witnessing violence is harmful, and take this into consideration when making visitation decisions.
- There is no age at which a child is immune to the effects of exposure to violence. Even an 11-month old child suffered consequences of such exposure, and improved after police intervention helped the mother feel safe, validating the importance of a systems approach.
- For young children, domestic violence is the most toxic form of exposure to violence.

In counseling sessions, children are not forced to talk about painful experiences before they're ready. Instead, each child is invited to draw a picture of her/his family or house. An analysis of individual drawings by children illustrated each of the clinical themes listed below. Children who have witnessed domestic violence tend to believe:

- No place is safe.
- Adults cannot protect themselves or their children.
- Keeping the secret of domestic violence is difficult and shameful.
- They (the children) are responsible for protecting the victim.

The children's drawings also revealed confusion and ambivalence about the abusive parent. The final clinical theme was that chronic fear leads to aggression.

Witnessing domestic violence affects children in a variety of ways, and some children are more resilient than others. The degree of resilience is affected by age, chronicity of the problem, presence of other risk factors (such as poverty, substance abuse, mental health problems), intrinsic personality/temperamental

variations, parents' ability to mediate the child's experience, and other supports in the extended family/environment.

<u>Morning Questions and Discussion</u>

The Child Witness to Violence Project is located right in the middle of Boston, and was founded to serve urban families with few resources. Although social and demographic factors would be expected to affect domestic violence, many constants remain. The study was replicated in Tulsa, OK, where extreme violence was less common, but moderate domestic violence occurred at frequencies comparable to those in Boston. McAlister Groves cautioned, "I think it's a dangerous myth to assume that violence is exclusive to poor communities or communities of color. If you look at the prevalence of violence, the variable that's most significant is economic resources – poverty. *Not* race, *not* ethnicity."

When asked about the effects on children of a single incident of physical violence, Edleson responded that the context of the incident is important, and that in some cases a single incident of violence was enough to terrorize a family for years.

Responding to a question about the efficacy of batterer intervention programs, Edleson praised a review by Gondolph (see references), and noted that many men drop out of intervention programs without consequences. Effectiveness of the programs is contingent on how consistently the system follows up. Interestingly, women say they feel safer after men have gone through a program, even though the violence may not have decreased. Edleson thinks the intervention programs are moderately effective overall, although there's no evidence that longer interventions (Washington State mandates 52 weeks) are more effective than shorter ones (30 weeks).

McAlister Groves recommended that all mental health practitioners be trained to be sensitive to these issues. Currently, many don't ask questions about a history of exposure to domestic violence. She also noted a specific need for groups for adolescents and adults, citing many calls from adults saying, "I grew up with this. Where can I get help?"

Assessing Children and Their Caretakers Regarding Domestic Violence Exposures

McAlister Groves began the afternoon by reiterating that DV occurs across all socioeconomic groups and geographic areas. What differs is how systems respond to DV. Affluence buys more privacy and means that families have more resources to deal with the stressors of DV. Most screening and intervention programs occur in low-income communities and communities of color. In more affluent communities, some health practitioners expressed concern they would lose their patients if they asked about domestic violence. A replication of the

Child Witness to Violence Project in nine Massachusetts communities revealed substantial differences in how systems responded to DV in the flagship (Boston) program. Now some programs are in hospitals and a range of host agencies; one may be in a DV shelter. The program should reflect the priorities and strengths of communities, and should require collaboration between mental health and social services providers.

The data on assessment were based on reviews of 149 closed cases of children age 0 to 6 years who were seen between 1992 and 2001. The charts included intake information, clinician's notes and observations, and outside reports and evaluations.

Boys were disproportionately represented: 109 boys to 40 girls. McAlister Groves did not know how to interpret this gender discrepancy, but offered some possibilities: that boys might show symptoms differently as young as infancy; that parents might interpret symptoms in boys differently than in girls; that mothers with toddler-age boys who are kicking and biting may worry that they will turn out like their fathers; that mothers are more concerned about aggression in boys than in girls.

Age at first exposure to violence was younger than 3 years in 61% of the sample, 3 to 6.9 years in 39%. The high incidence of exposure in infancy and toddlerhood raised the question of how family disruption since birth affected the development of secure attachment relationships.

Some mothers expressed concern that specific incidents might have affected their children. For example, a nursing mother noticed that when she became tense, her baby appeared to pick up on her tension, stopped nursing, and started crying. What happens when, repeatedly, infants' needs are not being met? The list of most frequently reported symptoms (below) suggests that the basic task of regulating emotion and anger is compromised in some children exposed to DV. Many of these symptoms are identical to the symptoms of post-traumatic stress disorder.

Most Frequently Reported Symptoms

Temper Tantrums/Angry Outbursts	60%
Aggressive with Peers	60%
Aggressive with Adults	56%
Demanding/Controlling	50%
Play re-enactment	41%
Nightmares	40%

Some unintended consequences can come with identifying children at risk. Although the goal is to find and help children who have been exposed to DV, we need to be careful in establishing protocols. McAlister Groves does not support instituting inflexible requirements – for example, that all pediatricians who find

some evidence of abuse will be obliged to report those incidents. The basic issue of safety may override what sometimes seems the right thing to do, and is intimately linked to the role that law enforcement plays in addressing the safety of children.

The goals of the CADV intervention are:

- To assess and improve the safety of the child and the non-abusing parent
- To provide the non-abusing parent with support, guidance, and information that can enhance her capacity to parent her child
- To address symptoms of trauma in the child
- To help the child place the traumatic experience in perspective and return to normal living

These interventions typically involve the child, parent(s), and a variety of systems supporting the child and family. For initial assessment, families are seen in a two-session clinic intake, usually with the non-offending parent and the child. One clinician meets with the child, another with the parent. Family members are seen in a flexible combination of joint and individual meetings, and the assessment consists of structured and unstructured components.

During the intake visit, it's important to determine the reason for the referral and identify the symptoms that most concern the caregiver. The caregiver will be asked about custody and legal issues affecting the family, the child's exposure to violence and other traumatic events, demographics, the child's developmental and behavioral history, and the caregiver's history. The interview offers an opportunity to assess the caregiver's reactions to the child's experience and symptoms (which can range from a keen awareness to denial and guilt). The interviewer also observes the interaction and attachment between child and caregiver in order to get an idea of the quality of the mother-child relationship.

The initial interview includes many open-ended questions in addition to more structured protocols such as the parent version of the Behavioral Assessment System for Children (BASC), the Parenting Stress Index (PSI), the Traumatic Events Screening Inventory (TESI), and the Trauma Symptom Checklist for Young Children (TSCYC). In a general danger assessment, information is solicited about severity of violence and injuries, weapons, substance abuse, excessive or obsessive jealousy (including stalking), mental illness (especially paranoia or delusions), and suicidal or homicidal threats. An assessment of high danger is likely to result in referral to Child Protective Services (CPS).

An assessment of risk to children includes:

- Proximity of the offending parent
- History of violence
- Severity and frequency of violence
- Threats to child's safety (e.g., kidnapping)
- Child's perception of violence

- Absence of support or safe havens for the child
- History of direct abuse of the child

If the child has been abused, reporting to CPS is mandatory, at least in the states of Massachusetts and Washington. Under other circumstances, however, it is not so clear whether a report should be filed. This "gray area" includes instances of a child who lives in a home where domestic violence occurs, but who has not been harmed and, in the absence of weapons and drug use, does not appear to be in danger.

McAlister Groves offered guidelines for filing a report as safely as possible:

- Inform the non-offending parent of your decision to report; assess the batterer's possible response; help to develop a safety plan.
- File against the violent partner, when appropriate.
- Report your safety concerns to the screener.
- Provide information about how DSS investigators may safely contact the non-offending parent (include information about the batterer's work schedule, license plate number, etc.).

First Afternoon Session Questions and Discussion

Edleson commented that, in Washington State, no law defines a child witnessing DV as a distinct form of child maltreatment. He emphasized the need to report if a counselor thinks a child has been abused or neglected – if there is any threat to a child's safety. Only about half the referrals for investigation are accepted.

McAlister Groves mentioned the possibility of calling anonymously. In Washington, some documentation of the caller's identity is required, reflecting concern about malicious calls. CPS can only investigate if the risk to the child is judged to be moderately high to high.

The audience was presented with a case study and asked if they would or would not make a report to CPS: The hypothetical couple has been married 12 years, with children ages 7 and 4. Tensions in the household are escalating, with many arguments about money. The husband thinks the wife spends too much time with friends and neglects the housework. He works long hours, and is grumpy when he gets home. In the precipitating incident, a child is sick, and the family is having pizza for dinner. The husband vents, throws the pizza against the wall. The children hear what is happening. The wife asks the husband to stop. The husband says, "I'll show them something to hear," and then throws dishes, one of which hits the wife.

A few members of the audience indicated that they would make a report. They were concerned with the statement, "I'll show them something to hear," and with the potential dangers inherent in throwing pizza and dishes. They felt they would be obliged to file a report in order to establish a public record of abuse.

The majority of the audience was reluctant to file a report, citing concerns about undermining the therapeutic relationship with the mother/client in a situation where CPS would be unlikely to take the case (since they would likely see the real issue as violence between the parents, not safety of the children). This audience contingent also was concerned with the possibility that reporting would make the mother and child *less* safe. They commented that neighbors without any background on the situation might call CPS, but a mandated reporter could have a different perspective. A person who works in the court system mentioned that, from the perspective of the court, “inconclusive” is often interpreted as “it didn’t happen.”

McAlister Groves felt that verbal and emotional abuse could be the heart of this particular issue. She assumed that all would agree that hearing the parents’ argument could be emotionally damaging to the children, but asked if CPS was the appropriate place to go with the problem. She suggested that more information was needed about things like family history of violence, weapons in the house, substance abuse, and previous physical injury. While some clinicians feel their job is to report rather than investigate, reporting without adequate information could actually increase the danger to women and children.

In a case like this, the goal would be to maximize the family’s access to services and appropriate use of CPS. The first afternoon session closed with a poignant anecdote of a battered woman who didn’t decide to leave until a report was made to CPS.

Effective Interventions for Children: Individual Therapy/Group Therapy Supporting the Non-Offending Caregiver

In this final session, Betsy McAlister Groves talked about assessment, then showed a videotape and led a discussion about how to assess the three children in the tape. For ethical reasons, the videotape did not depict a domestic violence situation.

When doing an assessment, we want to understand symptoms that interfere with functioning in school, making friends, and the rhythms of daily living (such as sleeping and eating). We also want to look at the strengths and competencies of the child and her/his family. Finally, we want to understand more about what the family violence means to the child. It’s easy for adults, perhaps especially mental health professionals, to make assumptions about what a violent event might mean to a child. But our interpretations of their drawings might be overlaid by our own preconceptions.

A child who doesn’t understand the events she witnesses may make up reasons why those events occurred, and may sometimes even assume responsibility for those events. As an example, McAlister Groves spoke of evaluating a 4-year-old

who survived a fire with her mother. The mother dropped the child out a window and then jumped herself. Through a doll-play exercise in which the child methodically pushed all the furniture and dolls out the window, the counselor learned that the child thought the mother had aggressively and purposefully pushed her out the window. With mother and child together, the mother was asked to retell the story from her point of view. This improved the child's understanding of the event, and her play changed after that.

The videotape concerned three siblings – Jackie (female, youngest child), Julie (female, middle child, developmentally delayed), and Joey (male, oldest) – who witnessed community violence and were referred to a counseling program. The children had been grocery shopping with their mother, and while unloading groceries from the back of the car, were unintentionally caught in the middle of a shooting on their street. The intended victim was a boy on a bike. Julie was struck on the foot, and her brother and sister witnessed the event.

While viewing the video of the counseling session, the audience was asked to think about how the kids might have been affected, what possible symptoms they might display, and the possible strengths in the children and/or their family. The key question was, "How do you hear children making meaning of this event?"

Audience members commented on their initial impressions of the children and their symptoms, noting that Jackie seemed to be taking on an adult role, often talking for Julie, and that Julie's development seemed a bit delayed (this observation was confirmed). Joey, whose pictures were more colorful and detailed, seemed more affected by the incident, perhaps, it was suggested, because he had tried, unsuccessfully, to save Julie.

McAlister Groves urged the audience to use the children's drawings, and the videotape, to think about the dynamics of the family. Which family members did and did not occur in the children's drawings? Who seems, through body language, to be holding things inside and hiding? How might one interpret the relative sizes of the figures in the drawings? Joey was feeling terrible – and very small (although he was the oldest child, and the only boy) because he had not been able to protect his sister. Therapeutically, it might be helpful to ask Joey how he – or anyone – could have protected his sister if he didn't know the shooting was going to occur.

The children revealed different kinds of strengths and coping strategies. For example, both Joey and Jackie experienced sleeping difficulties. Jackie was able to get to sleep by arranging all her stuffed animals around her, effectively creating a "safety" moat around the bed. Joey had a harder time of it, woke up with nightmares every night, and was terrified of sleeping alone. Jackie also talked about the event with lots of people, including her teacher, who provided the initial referral to the program. Joey, on the other hand, did not engage outside resources. His teacher reported that he simply sat in the back of the

room and “spaced out.” Although Jackie’s approach could be viewed as either a strength or a liability, McAlister Groves felt it reflected strength.

Articulate children who are able to express and name their feelings and explain what happened to them tend to do better. Those with no language for their feelings tend to do worse. It’s important to be able to focus on what one has control over, and on what one can do proactively. Art is a valuable tool in helping adults understand the child’s perspective. Vivid details in both Jackie’s and Joey’s drawings were remarkable.

Memory, however, can be inadvertently manipulated by beliefs and values. For example, Jackie remembered her mother shouting, before the shots, “Don’t go out, they’re shooting.” In fact, the mother yelled after the shooting had begun. But to Jackie, the moral of the story had been, “If you disobey your parents, bad things will happen.” Had she reordered the sequence of events because it gave her a better sense of being able to protect herself in the future? From a clinical perspective, McAlister Groves commented that she might have some concerns about Jackie in later years – perhaps in adolescence – because she had taken on so much adult responsibility as a young child.

Joey may have been afraid. He may have felt that boys were supposed to be tough and defend their families, and because he hadn’t been able to do that, he had to deal with a sense of failure. He was holding onto his feelings and sharing them, saying to himself that he didn’t know if he could ever go outside again. Joey was a particularly vulnerable child – a pre-adolescent who was moving inward. What might happen to him in adolescence? In attempting to be in control, he might be inclined to start drinking or to participate in gang activities. They key to helping him might be in his drawings, as he was very talented, a prime example of someone whose “feelings were at the tip of the marker.” One therapeutic approach might be to have Joey draw situations in which he could envision himself feeling safe outside.

Some guiding principles for interviewing parents include:

- First, consider the safety of the non-offending parent and child.
- Be respectful and mindful that parents usually feel intense guilt and shame at their failure to adequately protect their children from exposure to DV. Frame the therapeutic relationship as a partnership: We know bad things have happened and we all feel terrible about that, but we can move forward together.
- Don’t re-traumatize the parent; respect the process of establishing a relationship that will provide support for talking about painful issues. Don’t insist that they follow your timeline for talking about what happened.
- Respect a parent’s (and child’s) right not to talk. This may be challenging for CPS workers who are under severe time constraints to get information quickly.

McAlister Groves is often asked how she makes the decision about whether to refer a child for therapy. If a child seems to be doing fine, she probably would not refer for counseling. Some symptoms are normal responses to these kinds of events: they peak, and then diminish. If symptoms persist beyond three months, she might consider a referral. She would also be likely to refer if an injury extremely serious occurred, if the violence resulted in the death of a parent, if the parent is unable to be empathically tuned in to the child's distress, and if the child was directly abused.

Guidelines for preparing a child for therapy include:

- Determine what the child has been told.
- Offer guidelines to parents. Many parents don't prepare their child, perhaps telling him he's being taken to the doctor. A better approach is to tell the child he will be meeting someone who talks to lots of kids about fighting, and about what's been happening in the family.
- Give the child permission to talk honestly with the therapist.

When interviewing a child, McAlister Groves suggested the following:

- Describe your role and discuss confidentiality
- Honor the child's loyalty to the abusive parent. Don't communicate your judgment of that parent, or assure the child that "everything will be alright."
- Acknowledge the child's right *not* to speak.
- Don't make promises you can't keep.
- Communicate your concern about safety.

(Because of time constraints, McAlister Groves was not able to address all the topics covered in her handout. For information on CWVP Intake/assessment, structured protocols, dangerousness assessment, assessment of risk to children, reporting to CPS, filing more safely, and treatment modalities, please refer to pages 3 and 4 of the handout.)

The interviewer should always keep in mind that the primary areas of focus should be the child, the parent, and the relationship between child and parent.

In attempting to stabilize the environment for the child and the family, the following tips may be helpful:

- To increase safety for the family, the best way to help the child is to help the mother access safety.
- Provide advocacy, resource information, referrals, and assistance.
- Educate parents about the importance of stability, routine, and rituals in a child's life. Children in these circumstances often don't have a sense of constancy and stability (which can sometimes be provided by high-quality child care in which the expectations and schedule are clear and consistent). Providing some stability can lead to dramatic improvements in a short time, demonstrating how important the external environment can be. Bedtime and eating rituals are also supportive.

It is also important to give family members support and information about the trauma:

- Provide information about symptoms the child may display. Parents may feel overwhelmed about this. Explain that the child's responses are normal under the circumstances – children have many ways of communicating their fear.
- Provide support and assistance for parents to talk with their child about violence. This can be very difficult, especially if someone has died, or if a parent or caretaker has had the abuser arrested. But children can become very confused if presented with unclear or inaccurate information, or if confronted with unexplained grief experienced by an adult who is close to them. The child should not be required to take sides, and may experience strong feelings of anger and grief that they need to talk about.
- Provide referrals for therapy or other support. Parents need to help themselves too!

The child needs to know that the therapeutic situation is a safe place for expressing emotions. In this safe place, strategies can be devised for reducing symptoms such as increased arousal/activity level and recurrent dreams/nightmares and sleep difficulties. For example, for a child experiencing nightmares, one might have the child draw a picture of the nightmare, discuss it, then draw another picture of how s/he would like this nightmare to end. Imagining different outcomes often helps.

In response to a question about whether lots of children were misdiagnosed with AD/HD, McAlister Groves assented, but said that, since differential diagnosis in these cases can be difficult, it's important that practitioners establish the child's trauma history.

One of the major benefits of intervention is to provide activities that promote a child's competence and self-esteem. This is done by:

- Identifying the child's skills or talents.
- Providing activities that allow the child to demonstrate competence.
- Supporting other caregivers in their efforts to promote the child's competence and self-esteem.

Another important piece of the intervention puzzle is collaboration with agencies and care providers that are part of the child's life.

- Know the other care providers involved with the family.
- Make necessary referrals.
- Inquire about intervention goals from collaborating agencies.
- Provide effective advocacy for your client.

Under some circumstances, it can be clinically useful to the child to involve fathers in clinical treatment, although the mother must actively endorse and

support this idea before it is implemented. Father's involvement can occur as the result of request from the mother, father, or child, or from a court order. Potential goals for fathers' involvement include:

- Increased understanding of the child's perspective of the abuse and the impact of the abuse on the child.
- Acknowledgement of the abuse.
- Reparation or restoration of the relationship.

An ideal solution to meeting the challenges posed by children affected by domestic violence is broad and integrated community support for the family.

Second Afternoon Session Questions and Discussion

The first questioner objected to "friendly parent amendments," a concept that supports awarding custody to the parent who is most likely to foster the child's relationship with the other parent. This approach can be used when the non-custodial parent feels that the other parent is keeping him from the child. McAlister Groves responded that there are pitfalls to involving fathers in the intervention process. In particular, she would not involve fathers if custody was an issue. Edleson mentioned that he is editing a volume on parenting by fathers who batter their children. He emphasized that having open discussion in the family about what happened can be an enormous strength in parenting.

Another questioner suggested that education for judges could be very helpful. Edleson said he has heard judges lament the fact that a mother has repeatedly gone to a shelter and then returned to the abusive home situation, but he stressed that this behavior could be reframed as a sign of strength and an attempt to protect the children in the home.

Moving on to custody issues, a questioner asked if it was advisable to suspend the child's contact with the abusing parent, noting that sometimes the child seems more traumatized if s/he is not allowed to see the abusing parent. McAlister Groves responded that this is the crux of the visitation issue. It is also a clinical issue. At what point does lack of access to a parent become more traumatizing than exposure to violence? Some courts have decreed that the child can be re-traumatized by contact with the parent. But if the child has had an opportunity to deal with the initial trauma, it may be good to introduce supervised visits, gradually transitioning to unsupervised visits. Edleson added that visitation often becomes a negotiating strategy. If a father behaves well and the visitation center reports his good behavior, he may use that to manipulate the process to get access to the children and the mother. Edleson urged that this process be very carefully supervised by the court, and said it needs more regular review by judges and courts.

When asked about how decisions are made about a child's readiness for unsupervised visits with the father, McAlister Groves asserted that the therapist

working with the child should not be the person who makes that determination. Playing dual roles of custody evaluator and ongoing therapist is not advisable. A custody evaluation should call upon interviews with the mother, father, and child; and records on supervised visitations and from the child's therapist. Evaluators who do this work should understand the dynamics of domestic violence; currently many do not. Edleson concurred, stating that many evaluators are not trained well enough, are manipulated by the batterer, and come up with "incredible" advice to the court.

A domestic-violence survivor with experience in the courts commented on the benefits of educating herself and doing extensive reading. She was dismayed that the schools have discontinued a lot of music and arts programs, and said that now she has to pay to give her son these kinds of opportunities. McAlister Groves said her gut response is that art and music are good for all children. She has seen the same trend in Massachusetts, and thinks it's important to lobby for these activities for all children, especially those exposed to domestic violence.

Finally, a questioner asked about mothers who are victimized and then turns around and victimizes her children. McAlister Groves said such mothers should be reported to CPS. The best approach would be to try to help her with parenting, and with understanding her own behavior and her children's behaviors and responses. Often these women were victims when they were children, but McAlister Groves cautioned against oversimplifying the situation. She felt that she might approach these women in the same way as women who didn't abuse their children, but she would do it with the support of CPS.

Suggested Websites

Child Witness to Violence Project, Boston Medical Center
http://www.childwitnesstoviolence.org

MINCAVA Electronic Clearinghouse (comprehensive site on violence prevention)
http://www.mincava.umn.edu

Special site on Children & DV, Minnesota Center Against Violence & Abuse
http://www.mincava.umn.edu/link

Greenbook site (for federally funded projects to help agencies & courts work together)
http://www.thegreenbook.info

Minnesota Rural and Tribal Child and Adult Safety Project site
http://www.mincava.umn.edu/rural

USDOJ VAW Online Resources (online library of 150 full-length documents)
http://www.vaw.umn.edu

VAWnet Library (a great online library on violence against women)
http://www.vawnet.org

Suggested Online Readings

Edleson, J.L. (2004). Should childhood exposure to adult domestic violence be defined as child maltreatment under the law? In Jaffe, P.G., Baker, L.L. & Cunningham, A.J. (2004) (Eds.) *Protecting Children from Domestic Violence: Strategies for Community Intervention (pp. 8-29).* New York, NY: Guilford Press. (available online at http://www.mincava.umn.edu/link)

Edleson, J.L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5(2)*, 134-154. (Brief version available online at http://www.vaw.umn.edu/library/ccp/)

Edleson, J.L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14(8)*, 839-870. (Brief version available online at http://www.vaw.umn.edu/library/ccp/)

Edleson, J.L., Mbilinyi, L.F. & Shetty, S. (2003). *Parenting in the Context of Domestic Violence*. San Francisco, CA: Judicial Council of California. Online at http://www.mincava.umn.edu/link.

Gewirtz, A. & Edleson, J.L. (2004). Young children's exposure to adult domestic violence: The case for early childhood research and supports (Series Paper #6). In Schechter, S. (Ed.) *Early childhood, domestic violence, and poverty: Helping young children and their families.* Iowa City, IA: University of Iowa School of Social Work.(Online at http://www.uiowa.edu/~socialwk/publications.html)

Gondolph, E. (1995). Characteristics of batterers in a multi-state evaluation of batterer intervention.systems. (Online at http://www.mincava.umn.edu/papers/gondolf/batchar.htm)

National Council of Juvenile and Family Court Judges (1998). *Family Violence: Emerging Programs for Battered Mothers and Their Children.* Reno, NV: NCJFCJ. (Available online at http://www.ncjfcj.unr.edu/ under Family Violence or by calling NCJFCJ at 1-800-527-3223)

National Council of Juvenile and Family Court Judges (1999). *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy & Practice.* Reno, NV: NCJFCJ. (Executive summary and full document available online at http://www.thegreenbook.info or by calling NCJFCJ at 1-800-527-3223)