HOW DOMESTIC VIOLENCE EXPOSURE AFFECTS CHILDREN

BY

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Chair
How Domestic Violence Exposure Affects Children

Abstract

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Domestic violence is known to have detrimental effects on the health and well-being of individuals, especially on the children who are and have been exposed to abuse. In general, when mothers are safe from abuse, their children are then also safe from the abuse (Jeziorski, Lynch, Pharris & Sateren, 2004). Therefore, it is vital that providers who work with children, including nurse practitioners, fully grasp in entirety the subtleties of domestic violence, recognize domestic violence when it exists, and intervene properly. The effect that domestic violence has on mothers and their children will be discussed. These include identifying factors characterizing domestic violence, screening tools useful in assisting practitioners to identify domestic violence, and recommendations and referrals to community-based resources. These areas of discussion will give practitioners some guidance regarding best practices and advocacy for these children and their mothers.

Domestic violence presents risks for children physically, emotionally, and developmentally. Practitioners have a professional obligation to screen for domestic violence. Practitioners can contribute a vital role in intervening and halting the cycle of domestic violence.
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How Domestic Violence Exposure Affects Children

Introduction

Domestic violence has been identified as a public health epidemic in the United States (Martin, 2002). In fact, “Domestic violence has been considered the number one public health problem in the United States for some time (Martin, 2002), (Clements, Oxtoby & Ogle, 2008).” Physical violence is estimated to occur in 4 to 6 million intimate relationships each year (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999). Domestic violence accounts for more than half of the reported homicidal deaths of women in the United States. (Bureau of Justice Statistics, 2005)

Domestic violence perpetrators can be same-sex partners and women against men (Edleson & Nissley, 2006). Research on child exposure to domestic violence primarily focuses on “homes where a man is committing domestic violence against an adult woman, who is most often the child's mother (Edleson & Nissley, 2006, p. 1).”

Physical abuse is one of the major causes of injury to women in the United States. Statistics also reveal that in 95% of reported domestic violence cases, victims are female (www.turningpointservices.org, 2006). Mothers who are victims of domestic violence often feel judged by others (Jezierski, Lynch, Pharris & Sateren, 2004). Women delay seeking help thus their transition to recovery for both themselves and their children is delayed because they feel no one will believe them (Jezierski, Lynch, Pharris & Sateren, 2004). A study done on a women’s group therapy for domestic violence demonstrated 86% of women participating in this group therapy, had been seen by their health care professional within the past year, but only 1 in 3 revealed abuse during their visit (Jezierski, Lynch, Pharris & Sateren, 2004). Initially, abused mothers tend to turn to their
family first for help, rather than to providers, shelters and domestic violence advocates (Postmus, Severson, Berry & Ah Yoo, 2009). “Fear of perpetrator retribution and social stigma, cognitive schema regarding the significance and danger of violence, and fear of social consequences are among the reasons that help is often not sought (Blodgett, Behan, Erp, Harrington & Souers, 2008, p. 76).”

There has been an increased focus on matters related to domestic violence, such as its effects on children who observe the abuse of their mothers (Edleson & Nissley, 2006). Some of these effects include serious developmental, behavioral and emotional functioning of children (Edleson & Nissley, 2006).

Pinker, a professor in the Department of Psychology at Harvard University defines violence as being an act of human nature. Violence has been present since the beginning of time as evidenced by the many conflicts, wars and acts of cruelty documented towards human beings by other humans. “Human nature has not changed so much as to have lost its taste for violence (Pinker, 2007).” Social psychologists have found that at least 80% of Americans have fantasized about killing someone they don’t care for (Pinker, 2007). “What has changed, of course, is people’s willingness to act on these fantasies (Pinker, 2007).” Violence is still present in modern society, however it has become at least more concealed or less tolerable by the law and legislation. (Pinker, 2007).
Purpose

The purpose of this project is to understand the phenomenon of domestic violence as it occurs in the homes of children, to examine the specific effects of witnessing abuse of the mothers on these children, and to assist the nurse practitioner to providing appropriate support and resources to these children and their mothers. Although mothers and their children are not the only victims of domestic violence, as mentioned previously, they will be the persons of interest for this project.

Being a victim of domestic violence brings millions of women to health care services yearly (Gerberding, Falk, Arias & Hammond, 2007). Practitioners hold special status, enabling them to make an influential impact on the problem of domestic violence (Jezierski, Lynch, Pharris & Sateren, 2004). “Caring is the essence of nursing and sets the stage for a partnership, which fosters the autonomy and strengths of individuals, families, and communities, supporting them toward health (Jezierski, Lynch, Pharris & Sateren, 2004, p. 3).” Incorporating this role into practice, the practitioner as a primary care provider, can interact with these women presenting to them for their routine health care needs. Through the routine wellness care delivered to clients and their children, practitioners can be the front-line diagnosticians of domestic violence with the help of the screening tools available to them (Gerberding, Falk, Arias & Hammond, 2007).

Theoretical Framework

Special consideration should be given to the Cycle of Abuse Theory when confronted with assisting mothers and their children in homes where domestic violence occurs (Jezierski, Lynch, Pharris & Sateren, 2004). The Cycle of Abuse Theory is
described in three phases, with the first phase being tension building, next the acute battering or explosive phase, and then lastly, the honeymoon phase (Jezierski, Lynch, Pharris & Sateren 2004). (Please refer to Figure 1, an example diagram of the Cycle of Abuse (2006), used by the Legal Aid Society located in Clarksville, TN).

**Key Terms used and Definitions**

The following definitions were obtained from The American Heritage dictionary of The English Language 4th Edition (2000).

Domestic Violence- “not any single behavior but rather a pattern of many physical, sexual, and/or psychological behaviors perpetrated by a current or former intimate partner, and how these assaultive and coercive behaviors are designed to manipulate, control, and dominate the partner to achieve compliance and dependence (Hornor, 2005, p. 206)”

Resilience- The ability to recover from illness, change, or misfortune.

Protective factors- Factors that are adapted or intended to afford protection.

Juvenile Delinquency- “Persistent antisocial, illegal, or criminal behavior by children or adolescents to the degree that it cannot be controlled or corrected by the parents (Mosby's Medical dictionary, Elsevier, 8th edition, 2009.)”

Advocacy- Active Support of a population, cause, idea, or policy.

Community-based – A fortified center for operations that makes improvements within a community.

Screening tools- A systematic examination or assessment to detect an unwanted attribute.

Conduct disorders- To comport oneself in a specified way.
**Review of the Literature**

A variety of methods were used to perform a literature search for articles that provide current and ongoing research on the effects that domestic violence has on children, and the implications that this discovery has on a nurse practitioner's care of these children, their mothers and other affected family members.

A literature search between the years of 1990 and 2010 was conducted using the electronic databases CINAHL, PubMed and PsycINFO. Key terms used included “Domestic Violence” AND “Exposure on Children” AND “Resources” AND “Advocacy” AND “Implications for Practice” AND “Nurse Practitioner” AND “Community programs.” Over 20,000 articles were located that covered a multitude of subjects dealing primarily with prevalence of domestic violence, the mental and emotional affects of domestic violence on children, screening for domestic violence, and community-based programs and interventions. Twenty-eight articles were obtained using these key terms. The focus of narrowing this abundance of resources available was done by selecting the articles that focused more specifically on the practitioner's role in identifying domestic violence. References were also obtained using the very same key words in a Google search revealing community-based programs that are being trialed and/or are available as referral resources, making them a source of hope for the mothers and their children who are identified by the nurse practitioner as residing in homes where the children are or have been exposed to domestic violence.
Overview of Domestic Violence

Domestic Violence has been outlined very clearly in various historical documents dating as far back to the era of the Roman Empire (Sox, 2004). Domestic violence is recognized by an array of names, which include intimate partner abuse, family violence, wife beating, battering, marital abuse, and partner abuse (Hornor, 2005).

Domestic violence is defined as being "not any single behavior but rather a pattern of many physical, sexual, and/or psychological behaviors perpetrated by a current or former intimate partner. These assaultive and coercive behaviors are designed to manipulate, control, and dominate the partner to achieve compliance and dependence (Hornor, 2005, p. 206)"

Epidemiology of Domestic Violence and the Effects on Children

Women who are victims of abuse are often also mothers; hence, their children are also affected by their exposure to this witnessed abuse, whether it be physical, emotional or psychological (Child Welfare Information Gateway, 2003).

The Child Welfare Information Gateway (2003) provides access to information and resources to help protect children and strengthen families. It is a service of the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. (www.childwelfare.gov). According to the Child Welfare Information Gateway (2003), the children who are reared in homes where a parent is the victim of domestic violence are witnesses to this abuse. Somewhere between 3.3 and 10 million children yearly live in homes in the United States, where domestic violence is present, and witness acts of violence (Huth-Bocks, 2001), (English, Marshall & Stewart, 2003), (Blodgett, Behan, Erp, Harington & Souers, 2008). One in 25 children in the
United States, or at least one child in every classroom from elementary to high school ages, has had exposure to domestic violence in their home (Meltzer, Doos, Vostanis, Ford & Goodman, 2009).

A child's exposure to violence generally revolves around four main areas, actually witnessing the violence, hearing the violent act only, seeing the aftermath of the violence to include bruising and broken items, or someone else informing the child of the violence (Martin, 2002). A child observing their mother being abused can be as harmful as the child being abused themselves according to some researchers (Jezierski, Lynch, Pharris & Sateren, 2004). Child Welfare Information Gateway (2003) also categorizes two additional areas attempting to help the abused parent or becoming victims of abuse themselves. Children's exposure to domestic violence may include being utilized as a spy by the perpetrator to answer questions about the adult victim, being forced to view or contribute to the abuse of the victim, and being used as leverage by the abuser to convince the victim into remaining in the violent relationship (Child Information Gateway, 2003).

English (2003) discovered that between 45 and 75% of children in an abusive environment are maltreated by the abuser. Women and children are often badly injured while attempting to protect each other from the abuser (Mbilinyi, Edleson, Hagemeister & Beeman, 2007), (English, 2003). Martin (2002) in her exploration of this phenomenon found that 60 to 75% of families where domestic violence is present, the children are also being physically abused.

English (2003) elaborated further on the approximate 11 to 42% co-existence of domestic violence and child abuse and neglect. With this information, it is important for
the nurse practitioner to recognize the physical signs of child abuse. These include, "bruises on uncommonly injured body surfaces, blunt-instrument marks or burns, human hand marks or bite marks, multiple injuries at different stages of healing, evidence of poor care or failure to thrive, circumferential immersion burns and unexplained retinal hemorrhages (Pressel, p. 2)."

**Research Based Evidence of the Exposure of Domestic Violence and its Affects on Children**

Research studies between the years of 1995 and 2003, that were reviewed by Sox (2004), and Clement, Oxtoby & Ogle (2008), agree that witnessing domestic violence has an overwhelming negative effect on children. These children have five primary areas that are impacted as a result of witnessing family violence (Adams, 2006). According to Adams (2006), Ybarra et al (2007) and Sox (2004), these areas include impaired biological functioning, delayed behavioral, emotional, and cognitive development, and lastly impaired social adjustment. "Children's emotional and behavioral problems, when associated with domestic violence, can be considered as their efforts to adapt to a maladaptive environment related to the excessive stress experienced by the family associated with the domestic abuse (McFarlane, Watson & Hall, 2007, p. 76)." However, "The severity of the violence of the abused victim and extent of exposure to the child correlated with an increased risk of problems in all areas of functioning (Sox, 2004, p. 77)."

English, Marshall & Stewart (2003, p.54), found that domestic violence; "has a measurable and substantial association with caregiver and family functioning, which in turn have substantial association with child health and behavior." Several studies
reviewed by English (2003), and McFarlane, Watson & Hall (2007), reveal that children who reside in homes where domestic violence takes place demonstrate lower self-esteem, have increased anxiety, poorer school performance, and demonstrate more aggression and behavioral problems, and may often go on to adult criminal activity.

Social learning theory suggests that a child exposed to violence may also resort to violence (Edleson & Nissley, 2006). Intergenerational abuse and adult criminal behavior support this suggestion. It has also been documented that men exposed to adult domestic violence as a child are 3.8 times more likely to commit acts of domestic violence as an adult (Edleson & Nissley, 2006).

Gender has been found to be associated with more specific problem areas. Adams (2006) expands on this; adding that girls internalize problems, thus, experience depression, withdrawal, and have more somatic complaints. Boys tend to externalize their problems thus demonstrating more aggression and hostility (Adams, 2006). This is further supported by the finding that both age and gender play a role in the degree and presentation of the problems that children experience after witnessing domestic violence in the home (Meltzer, Doos, Vostanis, Ford & Goodman, 2009).

Adams (2006) describes a qualitative study suggesting that children who witnessed domestic violence tended to demonstrate aggressive behavior at school, and poorer concentration in the classroom. Adams (2006) hypothesized that one of the primary reasons for the poor concentration may be out of worry as to what may be happening to their victimized mother at home. These children often miss school due to their fears of leaving their mothers alone with the abuser. These same children have strained relationships with their mothers, as well (Adams, 2006).
A growing body of research continues to reinforce the finding that children who witness domestic violence are more than likely to develop conduct and emotional disorders (Meltzer et al, 2009). Conduct and emotional disorders include Attention Deficit and Hyperactivity Disorder (ADHD). The stress of witnessing domestic violence in the home can also play a role in aggravating the onset of ADHD symptoms (Becker & McCloskey, 2002).

Meltzer et al, (2009, p. 499), further state that “Witnessing domestic violence may teach children that violence is an acceptable way of resolving conflicts.” This suggests that children may resort to physical fights in school, gang affiliation and juvenile delinquency. Often these children are labeled as problem children and trouble makers by teachers (Adams, 2006). A child's exposure to domestic violence in the home is connected with the role it plays in juvenile crimes (Fields, 2003). A recent study involving about 2,200 children demonstrated that domestic violence in the home was a causative factor in a child's violent behavior (Fields, 2003). This study suggested that children who witness domestic violence usually imitate the abuser's violent strategies when dealing with others (Fields, 2003). As stated before, a child’s resilience to their exposure to domestic violence can play a major role in whether or not children have problems in any of these areas (Sox, 2004).

**Post-Traumatic Stress Disorder**

An emerging body of research postulates that witnessing domestic violence prompts the development of Post-Traumatic Stress Disorder in children (Adams, 2006). The National Institute of Mental Health (NIMH) (2008) states that a person “can contract Post-Traumatic Stress Disorder (PTSD) after living through or seeing a dangerous event,
such as war, a hurricane, or bad accident.” The NIMH (2008) further clarifies that the sufferer will experience PTSD after being forced to relive or experience the event, or being exposed to an event that reminds the person of the initial traumatizing event.

There are a variety of programs that are being trialed to help treat children who suffer from PTSD. The majority of treatments for children with PTSD have primarily been psychotherapeutic in nature, helping the child gain mastery over the event causing the PTSD (Deykin, 1999). More specifically, Vickerman & Margolin (2007) reviewed existing programs for youth who have been exposed to domestic violence. The focus of these successful programs include those that work on decreasing both the externalizing and internalizing symptoms of PTSD in children who have witnessed domestic violence, decreasing behavioral problems and depression experienced by these children, improving violence attitudes of these children, and increasing feelings of competency, happiness and social relationship functioning in these children. Examples of these programs include, Child-Parent Psychotherapy, The Kids Club, Trauma-Focused Cognitive Behavioral Therapy, The Youth Relationships Project, Parent-Child Interaction Therapy, The Learning Club, and Project SUPPORT (Vickerman & Margolin, 2007).

**Social-economic Class and Domestic Violence Exposure**

“Although poor families are more likely to experience interpersonal violence, it occurs at all income levels (Jezierski, Lynch, Pharris & Sateren, 2004, p. 17).” Research continues to show a strong correlation between lower socio-economic factors and the increased likelihood of becoming witnesses of domestic violence (Meltzer, 2009). In fact, “poor families may be identified more often, because they often have more contact with social service agencies (Jezierski, Lynch, Pharris & Sateren, 2004, p. 17).”
The American Bar Association Commission On Domestic Violence (2010), founded in 1994, performed a survey to document recent statistics, which demonstrated that as many as 50 to 60% of women who were awarded public benefits were also victims of domestic violence, as opposed to 22% of the general population. Public welfare programs exist for those who make little or no income. Rates of domestic violence as high as 82%, have been reported by women who were receiving welfare benefits (American Bar Association, 2010). These recent statistics are supported by the following, “A substantial proportion of women on welfare experience domestic violence in their lifetimes, and the prevalence of domestic violence is higher than in comparable national samples and higher than in samples of low-income women who are not on welfare (Tolman & Raphael, 2000, p. 3).”

Research has suggested that children can demonstrate additional developmental problems exclusive to their physical, psychological, and social development (English et al, 2003); (McFarlane et al, 2007). According to McFarlane et al, (2007), and Child Welfare Information Gateway (2003), “infants exposed to violence may have difficulty developing attachments with their caregivers and in extreme cases suffer from "failure to thrive," preschool children may regress developmentally or suffer from eating and sleep disturbances, school-aged children may struggle with peer relationships, academic performance, and emotional stability, and lastly, adolescents are at a higher risk for either perpetrating or becoming victims of teen dating violence.” There are limitations and uncertainties to the research since some of the children in such studies do not show elevated problem levels, even under similar circumstances (Children Welfare Information Gateway, 2003); (Sox, 2004).
Advocacy and Implications for Practice

"Nursing practice is driven by a unique set of ethical principles focused on patient advocacy and empowerment (Jezierski, Lynch, Pharris & Sateren, 2004, p. 28)." The nurse practitioner's response to victims of domestic violence, "requires sensitivity rooted in understanding how it differs from other types of violence (Jezierski, Lynch, Pharris & Sateren, 2004, p. 4)." It is "imperative that primary care providers, including nurse practitioners, understand the dynamics of domestic violence, recognize domestic violence, and intervene appropriately (Hornor, 2005, p. 206)." Therefore, "Timely identification of domestic violence coupled with appropriate intervention and referral by the primary care provider is crucial in minimizing the effects of domestic violence on children and other family members (Hornor, 2005, p.209)."

Practitioners need to recognize "that their role is not to prescribe, decide or judge what a patient should do, but rather to partner with the patient to provide information and resources for informed decisions (Jezierski, Lynch, Pharris & Sateren, 2004). Nurse practitioners have a responsibility to question their patients about domestic violence as part of their assessment ( Hornor, 2005 ). Also, practitioners are mandatory reporters of known and suspected abuse of any kind (Jezierski, Lynch, Pharris & Sateren, 2004).

"Universal screening of adults for domestic or intimate partner abuse has been strongly advocated by nurse and physician leaders throughout the country, and it is now recommended that all clients, adolescent and elders, be screened (Jezierski, Lynch, Pharris, Sateren, 2004, p. 32)." Screening for domestic violence should be incorporated into ongoing assessments, because early discovery of domestic violence can help to
ensure appropriate interventions and can serve as a source of hope for the children who witness violence in the home (Martin, 2002).

The American Nurses Association and the American Medical Association are two professional groups that highly support the use of screening tools for domestic violence (McFarlane et al, 2007). According to Mezey (2001), the Department of Health has a published resource manual that encourages health professionals to include in their routine clinical assessments, questions about domestic violence. The American Academy of Pediatrics committee on Child Abuse and Neglect also recommends routine screening of all mothers for domestic violence, when the children are brought in for their well-child check (McFarlane et al, 2007); (Siegel, Hill, Henderson, Ernst, & Boat, 1999).

The manner in which the practitioner conducts their assessment is important in facilitating disclosure of domestic violence in the home (Jezierski, Lynch, Pharris & Sateren, 2004). Questions should be brought up only in a private, empathetic, non-judgmental manner (Hornor, 2005). One should never criticize, but only be supportive and assure the mother that any form of abuse is simply not acceptable in any relationship (Hornor, 2005). Mothers have been found to accurately report their children's behaviors and reactions to the witnessed domestic violence when assessed in this way (Lemmey, McFarlane, Wilson & Malecha, 2001).

The practitioner should help every mother in an identified abusive relationship formulate a safety plan in order to leave the abusive environment, and the practitioner needs to understand that the mother will know when it is the best time to leave the relationship (Hornor, 2005). The decision to leave can escalate the cycle of abuse (Hornor, 2005).
Research has shown that screening for domestic violence is acknowledged and desired by women victims (McFarlane et al, 2007). Women are more motivated to seek help when they are made to realize that it is important to protect their children from the exposure and sequelae of domestic violence (Martin, 2002). Mothers will report domestic violence by an intimate partner more readily, when addressed in a nonjudgmental, non-confronting manner (Erickson et al, 2001).

**Tips in screening for Domestic Violence in the Home**

Assessment strategies for the nurse practitioner to utilize as recognized by the Family Violence Prevention Fund (2007) include, assessing the immediate safety needs of the mother and her children. The pattern and history of the abuse within the home, and the mother's current access to advocacy and support resources should be assessed. “Practitioners fail to document a history of abuse in about three quarters of women who have experienced it (Richardson, Coid, Petruckevitch, Chung, Moorey & Feder, 2009, p. 1).” The nurse practitioner who repeatedly demonstrates their concern about the mother and child's safety is better able to build the needed rapport and trust that can help a mother disclose and/or continue to disclose the abuse within the home, eventually disrupting the cycle of abuse (Lemmey, McFarlane, Wilson & Malecha, 2001).

**Useful Assessment Tools**

There are several assessment tools available for practitioners to incorporate into their patient care and help them identify current or ongoing abuse in the home. The assessment screens chosen for this paper, had high reliability and validity, and are less than 20 questions, which is feasible in most healthcare settings (Family Violence prevention Fund, 2007). According to McFarlane et al (2007, p. 79), “The Abuse
Assessment Screen, developed and tested by nursing scholars, is available in several languages, is used widely in a number of settings, and can be easily obtained" (See Table 1).

The Family Violence Prevention Fund (2007) in conjunction with The Center for Disease Control and Prevention (2007), offers several assessment screens that can be used in identifying domestic violence. The American Medical Association Screening Questions is a 10- item list that inquires about physical, sexual and emotional abuse (See Table 2). The Domestic Violence Initiative Screening Questions is a 6- item questionnaire that assesses for emotional and physical abuse, and desired professional assistance (See Table 3).

In the Pediatric setting there are several useful screening tools for domestic violence. One is the Domestic Violence Screening for Pediatric Settings, which is a 6- item sample questionnaire that assesses for the occurrence of domestic violence in the home (See Table 4). Another Pediatric assessment scale is the Falmouth Pediatric Associates Violence Handout. This is a five- item questionnaire that assesses for domestic violence, handguns in the home, and for previous inquiries by health care providers in regards to domestic violence (See Table 5).

According to Martin (2002), two of the more reliable and more valid tools that the nurse practitioner can use in various patient situations, including children who have been exposed to domestic violence, are the Child Behavior Checklist (CBCL) specific for externalized behaviors, and the Internalizing Symptoms Scale for Children (ISSC) (Martin, 2002). According to the Education Resources Information Center (1994), the CBCL was “created as a standardized tool for recording the behaviors of children aged 4
through 16 as reported by their parents or caretakers, and since its inception in 1983, the CBCL has been applied and tested on numerous clinical samples, yielding an impressive body of quantitative support.” The ISSC, according to Merrel & Walters (2001), “was developed to provide a screening and assessment self-report tool for research and clinical evaluation of internalizing symptoms associated with depression, anxiety, somatic problems, social withdrawal, and various types of affect in children.”

Martin (2002) adds that the CBCL and ISSC are two specific, useful tools that are both reliable in clinical assessment and ongoing research. These tools help the provider to quantify baseline emotional and behavioral issues in children who have been exposed to domestic violence.

**Resilience and Protective Factors**

Promoting resilience in clients is important. Resilience is a vital defense mechanism of children. Resilience is defined as “having good outcomes in spite of serious threats to adaptation and development (Martin, 2002, p. 11).” Resilience often depends on a child's protective factors. In order to carry out a plan to promote resiliency, the practitioner needs to include the enrichment of these protective factors.

Protective factors are certain qualities or conditions that when present increase the health and well-being of children, and allow children to do well even under stress, because they serve as the buffers, resources, support and coping skills they need to withstand these stressful experiences (Child Information Gateway, 2003).

Martin (2002, p. 11-12) and Child Welfare Information Gateway (2003) further state that the practitioner should reinforce the following protective factors: including, “social competence, intelligence, high self-esteem, outgoing temperament, strong sibling
and peer relationships, and a supportive relationship with an adult.” These qualities help safeguard the children who have encountered domestic violence.

**Intervention for Children and their Mothers**

"Comprehensive assessment followed by targeted intervention may enable children to obtain the services that are most warranted (Spilsbury, Kahana, Drotar, Creeden, Flannery & Friedman, 2008. p. 14).” Often, mother and children still currently reside with the abuser. When working with these women and their children, it is important to recommend developing a safety plan, referrals to community counseling, legal assistance, and protective shelters (McFarlane et al, 2007). Once domestic violence exposure has been identified by the practitioner goals for effectively responding to the identified domestic violence within the home should be set. The goals are discussed and set collaboratively with the client, so the mother takes on an active role in the decision process in keeping her children safe.

According to the Family Violence Prevention Fund, appropriate goals include increasing the family's safety (Basile, Hertz & Back, 2007). Safety planning is the most important goal. Practitioners should encourage each mother to make her own safety plan. An essential part of the practitioner's role includes, listening to the mother and providing validating statements, such as “I care. I am glad you told me. I am concerned. This is harmful to you and your children, you are all vulnerable (Basile, Hertz & Back, 2007.)”

A safety plan is a set of simple, but critical steps that can be carried out when your personal safety is threatened or being jeopardized. According to the Family Violence Prevention Fund, a safety plan begins with the question directed towards the mother, does she plan to leave (Basile, Hertz & Back, 2007)? If she does not plan to
leave at the current moment, does she know when to implement it? If she is going to
leave the abuser, does she have friends or family to stay with? If not, does she want to go
to a battered women's shelter? Does she want to contact police to obtain an order of
protection? Encourage her to keep in a safe place keys to house and car, important
identification papers, cash, food stamps, extra clothes, medications and supplies. Discuss
safety measures to include keeping doors and windows locked, and making arrangements
with schools and daycare centers so that they release the children to only designated
persons (Basile, Hertz & Back, 2007).

Additional goals include making referrals to local resources, community-based
programs, and most importantly, follow-up steps for practitioners (Basile, Hertz & Back,
2007). These follow-up steps include scheduling future appointments on a weekly basis
to ensure that the mother and children have a solid connection to their practitioner. The
frequency of visits can lessen, once the safety of the mother and her children is
established, then the visits can become monthly, and on an as needed basis, to evaluate
whether the referrals to local resources and programs are meeting their needs.

Another intervention service for children exposed to domestic violence includes
building group cohesion, in a facilitated group discussion, addressing violence issues
(Schewe, 2008). A primary goal of these group discussions is to promote open discussion
of a child's experience with domestic violence. In group discussions, facilitated by
skilled counselors, children are helped to understand why their parents fight and to realize
that it is not their fault. Therapeutic group interventions such as this, help children
identify their feelings, manage anger, identify and use social supports, and improve self-
concepts and self-confidence. Children are also taught about the cycle of violence,
increasing safety and stability, and dealing with specific symptoms experienced by children exposed to domestic violence, such as insomnia and nightmares. Practitioners might guide the parents and children into developing comforting bedtime routines.

Mothers and their children should ideally, have ongoing assessments by the nurse practitioner determining their readiness for intervention services available to them, such as input from mental health services. An assessment of a client's readiness for intervention services should take place at every visit to the office (Meltzer, 2009).

**Examples of Community Based Programs Considered for Intervention When Domestic Violence is Discovered in the Home**

"Family support services are community-based services that assist and support parents in their role as caregivers," and "family support services promote parental competency and healthy child development by helping parents enhance their strengths and resolve problems that can lead to child maltreatment, developmental delays, and family disruption (Child Welfare Information Gateway, 2003)."

Using the model of The Child Welfare Information Gateway (2003), prevention and intervention programs incorporating various teaching tools, and given appropriate timing, can provide opportunities for mothers and children that may improve parents' effectiveness, improve a child's social skills, minimize adjustment problems, and lastly, enhance a child's coping during and after their exposure to domestic violence (Graham-Bermann, Lynch, Banyard, DeVoe & Halabu, 2007).

In evaluating community-based, interventional programs for children, Graham-Bermann et al, (2007), discuss a program that was trialed based on social learning principles concentrating on parenting skills and behavioral issues of children. The focus
group was, children and their mothers who were leaving battered women's shelters (Graham-Bermann et al, 2007). In this study, 36 children who were diagnosed with either a conduct disorder or oppositional defiance was placed into either an interventional or comparison group (Graham-Bermann et al, 2007). This interventional program was successful in reducing the behavioral problems found in children who have been exposed to domestic violence. This program played a role in bettering the mother’s parenting skills and decreasing the children’s aggressive behaviors and at a 16-month follow-up, these improvements were being maintained (Graham-Bermann et al, 2007).

Family Connections is a group program that is aimed at women and their children who are residing in shelters, and is based on the principles of Theraplay. Bennett, Shiner & Ryan (2006, p.41), define Theraplay as “an attachment-based treatment approach designed for children and adults experiencing a variety of behavioral and attachment-related difficulties.” Theraplay “draws on a broad knowledge base in the areas of human relatedness and child development, in particular, the role of the mother-child relationship in children’s well-being (p. 41).” The program focus was to assist in mother-child attachment, help the mother recognize and promote her role as parent, educating the mothers and their children in violence and its outcome, and finally, increasing the family’s integrity and over all well-being. The Family Connections Theraplay program is not able to affirm desired outcomes in regards to behavioral problems or reactions to violence, given the short shelter stays, but it can affirm to have bettered the quality of life for these mothers and their children, while residing at the shelter (Bennett, Shiner & Ryan, 2006).
The subsequent home visiting programs have put into practice potential interventions explicitly intended to improve outcomes for women and children exposed to domestic violence (Family Violence Prevention Fund, 2010). One such program developed in New Haven, Connecticut, an area that is characterized by a high rate of poverty and ethnic mixture (Stover, Rainey, Berkman & Marans, 2008). This program, known as the Domestic Violence Home Visit Intervention (DVHVI), was developed in the year 2000 with the co-joined support of the United States Justice Department Office on Violence Against Women, a team of police supervisors, and mental health clinicians and other advocates as a service to mothers and their children who are victims of domestic violence (Stover, Rainey, Berkman & Marans, 2008). The purpose of this program is to monitor and address ongoing safety concerns, provide the family with information in regards to community resources available, and deal with some of the causal problems that lead to domestic violence incidents (Stover, Rainey, Berkman & Marans, 2008). The DVHVI program is “unique in the degree to which it integrates police intervention with battered women’s advocacy and a focus on children (Stover, Rainey, Berkman & Marans, 2008, p. 1434).” Although this program included women of Caucasian, African-American, Asian and Hispanic ethnicities, it over all proved most beneficial to the Hispanic women (Stover, Rainey, Berkman & Marans, 2008).

Crisis intervention and outreach approaches for the mothers and their children work well in conjunction with formal treatment plans, such as cognitive behavior therapy (Blodgett, Behan, Erp, Harrington & Sowers, 2008). Cognitive behavior therapy is an evidenced-based method of treatment for children who fall between the ages of 3 and 18.
who are being or have been exposed to domestic violence (Blodgett, Behan, Erp, Harrington & Souers, 2008).

Safe Start crisis and outreach program was developed in Spokane, Washington, and took on a similar approach to the home visiting program developed in the New Haven Policing Model (Blodgett, Behan, Erp, Harrington & Souers, 2008). Referrals initially came from mostly law enforcement agencies and then thereafter, additional referrals came from an array of sources to include social and educational agencies, child protection services, and domestic violence advocates. The purpose of Safe Start crisis and outreach program was to expand the referral sources and heighten the community's overall awareness of a child's exposure to domestic violence.

With Safe Start, there was a benefit to the mother and children being exposed to domestic violence. This benefit was evidenced by one or more of the following: mother ending the violent relationship, improving functional adjustment, such as being able to obtain a stable home, continuing contact with health and social services recommended by the practitioner, and significantly improved mood and behavior in the children (Blodgett, Behan, Erp, Harrington & Souers, 2008).

Project Support is an inclusive home-based intervention plan that aims to decrease conduct disorders in the children exposed to domestic violence, and is at present utilized in a number of urban and suburban domestic violence programs in Dallas, Texas (Family Violence Prevention Fund, 2010). The home visits take place with mothers who upon their leaving a battered women's shelter, have at least one child displaying a conduct problem such as defiance. This intervention plan concentrates on two areas, one area
includes assisting mothers to help them develop their child management skills, and secondly, offer emotional support to these mothers. This program demonstrated to be successful, because mothers who were in receipt of these services exhibited less inconsistent and insensitive parenting, thus improved children’s conduct (Family Violence Prevention Fund, 2010).

The Child and Family Interagency Resource, Support, and Training Program (Child FIRST), focuses on assisting children five years old and younger, who are at risk for developmental delays, or social, emotional, or behavioral problems (Crusto et al, 2008). This program places primary emphasis on the attachment relationship being that this relationship plays a central role in a child's development safety and trust. This community-based program performs assessments on the families referred to them, to include screening for developmental and emotional problems, violence exposure on the children within the home, assessment of a family's strengths, weaknesses, needs and lastly functioning (Crusto et al, 2008). Child FIRST implements a plan of services and supports for these families. The desired goals include decreasing a child's exposure to domestic violence, decreasing parental stress, and ensuring a connection to resources and supports within the community that will enhance family stability and overall health and well being of these families (Crusto et al, 2008).

**Summary and Conclusion**

Domestic violence exposure for children in general research indicates that children feel safe when their mothers feel safe. Understanding what domestic violence is, identifying those mothers and children, who have been affected by this problem, with the
appropriate assessment tools, and making best practice interventions, including referrals and recommendations to community-based resources, are important for the practitioner to incorporate into their care of mothers and their children who are victims of domestic violence. No one deserves to be hurt or abused in any fashion. Domestic violence exposure and its consequences for children, is one of the most profound and troubling issues that children are experiencing today (Adams, 2006). It has been identified by healthcare professionals as a public health epidemic, so given this, practitioners need to make it a priority within their practice to screen families who present to them for care, and identify the abuse within the home early in order to offer hope and services for these mothers and their children. By ensuring appropriate follow-up and referrals to services in the community, practitioners are then providing these families with the holistic care that each family deserves.
Table 1
(The Center for Disease Control and Prevention, 2007).

Abuse Assessment Screen
Instructions: Circle Yes or No for each question
1. Have you ever been emotionally or physically abused by your partner or someone important
to you? YES NO
2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? YES NO
   If YES, who? (Circle all that apply)
   Husband Ex-Husband Boyfriend Stranger Other Multiple
   Total no. of times
3. Since you’ve been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? YES NO
   If YES, who? (Circle all that apply)
   Husband Ex-Husband Boyfriend Stranger Other Multiple
   Total no. of times

Mark the area of injury on the body map. Score each incident according to the following scale:
SCORE
1 = Threats of abuse including use of weapon
2 = Slapping, pushing; no injuries and/or lasting pain
3 = Punching, kicking, bruises, cuts, and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon
4. Within the last year, has anyone forced you to have sexual activities? YES NO
   If YES, who? (Circle all that apply)
   Husband Ex-Husband Boyfriend Stranger Other Multiple
   Total no. of times
5. Are you afraid of your partner or anyone you listed above? YES NO
American Medical Association Screening Questions
1. Are you in a relationship in which you have been physically hurt or threatened by your partner?
2. Are you in a relationship in which you felt you were treated badly? In what ways?
3. Has your partner ever destroyed things that you cared about?
4. Has your partner ever threatened or abused your children?
5. Has your partner ever forced you to have sex when you didn’t want to? Does he force you to engage in sex that makes you feel uncomfortable?
6. We all fight at home. What happens when you and your partner fight or disagree?
7. Do you ever feel afraid of your partner?
8. Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
9. You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
10. Do you have guns in your home? Has your partner ever threatened to use them when he was angry?
Table 3  
(The Center for Disease Control and Prevention, 2007)

Domestic Violence Initiative Screening Questions

*Health worker to explain the following in own words:*  
- In this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home;  
- This is because violence is very common and we want to improve our response to families experiencing violence.

*Health worker to ask the following questions of ALL female patients on their own:*  
1. Are you ever afraid of your partner? YES NO  
2. In the last year, has your partner hit, kicked, punched or otherwise hurt you? YES NO  
3. In the last year, has your partner put you down, humiliated you or tried to control what you can do? YES NO  
4. In the last year, has your partner threatened to hurt you? YES NO  

*If domestic violence has been identified in any of the above questions, continue to questions 5 and 6.*

5. Would you like help with any of this now? YES NO  
6. Would you like us to send a copy of this form to your doctor? YES NO  

Name of Doctor: ____________________________  
Address: ________________________________  
_____________________________________________________________________________  
_____________________________________________________________________________  
_____________________________________________________________________________  

Signature of Client ____________________________  

Date ________________________________  

**IF THIS FORM WAS NOT COMPLETED PLEASE SCREEN ON NEXT VISIT**

**DV Risk Status:**  
Domestic Violence not identified □  
Domestic Violence identified, refused help □  
Domestic Violence identified, help provided □  

**Provided With:**  
Contact phone numbers for DV □  
Written information for DV □  
Referral to hospital-based service □  
Referral to community DV service □  
Referral to GP □  
Other: ________________________________

**Screening Not Completed Due to:**  

| 28 |
Presence of partner ☐
Presence of family member/friend ☐
Absence of interpreter ☐
Woman refused to answer the questions ☐
Additional Comments:

Signature of Health Professional:

Date:
Table 4
(The Center for Disease Control and Prevention, 2007)

*Domestic Violence Screen for Pediatric Settings*

1. Are you in a relationship now or have you ever been in a relationship in which you have been harmed or felt afraid of your partner?
2. Has your partner ever hurt any of your children?
3. Are you afraid of your current partner?
4. Do you have any pets in the house?
5. Has your partner or child ever threatened or hurt any of the pets?
6. Are there any guns in your house?
Table 5
(The Center for Disease Control and Prevention, 2007)

_Falmouth Pediatric Associates Violence Handout_

Today’s Date ______
Child’s Name (optional) ______________________ Child’s Date of Birth ___/___/___
Mother’s Name (optional) ______________________ Mother’s Date of Birth ___/___/___

Please confirm that the person filling out this form is the child’s mother
Y N
In your current relationship, have you ever been harmed or felt afraid of your partner?
Y N No current relationship
In a previous relationship, have you ever been harmed or felt afraid of your partner?
Y N
Has your current or past partner harmed any of your children?
Y N
Are there any guns in your home?
Y N
Has any health professional ever asked you about domestic violence before?
Y N
Figure 1

cycle of violence
References


Statistics of Battered Women: Retrieved from:


http://findarticles.com/p/articles/mi_m0341/is_4_56/ai_704600201/?tag=content;col1.
