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Mental Health Services for Children Who Witness Domestic Violence

Betsy McAlister Groves

Abstract

Exposure to domestic violence has significant negative repercussions for children's social, emotional, and academic functioning. In the past decade, mental health professionals have developed treatment programs and approaches aimed at mitigating these deleterious effects. Their efforts, however, are often hampered by difficulty identifying and gaining access to the target population because the occurrence of domestic violence remains a family secret in many households.

Clinicians and researchers have published descriptions of group and individual therapy approaches for children who witness domestic violence. These approaches share several goals: promoting open discussion about children's experiences with domestic violence, helping children to deal with the emotions and consequences that follow such exposure, reducing the problematic symptoms children experience, strengthening children's relationships with their nonabusive caregivers, and helping children and their families to create and maintain relationships and living situations that are free from violence and abuse. One limitation of the literature describing these interventions is the absence of controlled outcome studies demonstrating the effects of these programs, in the short and long terms. Thus, development of such evaluative components is an important future direction for this field. Some of the other challenges that confront clinicians include working with children's families, addressing children's complex and intense emotional experiences, and determining whether children have themselves been victims of abuse or neglect (and then interfacing with child protective services).

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In the past decade, a growing body of empirical research has demonstrated that exposure to domestic violence deleteriously affects children's social, emotional, and cognitive development.¹ Furthermore, data suggest that such exposure has long-term consequences for children's well-being, ultimately affecting their adult functioning.² Given the negative repercussions of children's exposure to domestic violence, there exists a need for programs that can intervene in these children's lives to improve their potential for healthy psychological adjustment.

Whereas national awareness of the impact of domestic violence on women has grown in recent years, recognition of the needs of children who witness such violence has lagged behind. Yet, interest in and concern about children who witness domestic violence appear to be growing in the private and public sectors. The mental health professions are increasingly identifying the special needs of these children. The published literature contains thoughtful theoretical formulations about these children's experiences and needs, as well as descriptions of model intervention programs and approaches. Because service provisions to children who witness domestic violence is in the early phases of development, uniform standards of care do not yet exist and there is no comprehensive listing of programs. In addition, empirical data addressing the efficacy of most therapeutic approaches is sparse.

Despite these limitations, however, there is promise in published reports and discussions that constitute a first building block in a field where increasing effort, attention, and funding may be directed in the future. This article summarizes the state of knowledge as reflected in the current mental health literature. The article first briefly summarizes the findings about the effects of witnessing domestic violence on children, then reviews the issues relating to identification and assessment of such children. In its examination of the treatment programs and approaches, it discusses the goals and models of service delivery, intervention approaches and techniques, and what is known about the effectiveness of these therapies. The final sections of this article address some of the challenges inherent in working with this population, funding issues, and recommendations for future directions in this field.

The Effects of Exposure to Domestic Violence on Children

Children's responses to their experiences with domestic violence vary. Children may reveal any of a range of adjustment problems and psychopathology, or may emerge from their experiences relatively unscathed.¹ Factors that appear to affect these responses include the child's proximity to the violence (that is, what the child actually saw or heard), the child's temperament, the age of the child at the time(s) of exposure, the severity and chronicity of the violence, and the availability of adults who can emotion-

ally protect or sustain the child. Research reveals that some of the symptoms these children may display include aggressive behavior, reduced social competencies, depression, fears, anxiety, sleep disturbances, and learning problems.¹ Underlying many of those problems are the children's emotional responses to the violence, such as intense terror, fear of death, and fear of loss of a parent. In addition, children may harbor rage, feelings of guilt, and a sense of responsibility for the violence. Children who witness traumatic events, such as incidents of domestic violence, may feel helpless and see the world as unpredictable, hostile, and threatening.

Overall, data indicate that children who live in households affected by domestic violence may suffer extensively and are vulnerable to developing a host of short- and long-term problems. (For more information about the effects on children of exposure to domestic violence, see the article by Fantuzzo and Mohr in this journal issue.)

Identification and Assessment

The first challenge to providing services to children who witness domestic violence is identifying this population. Once these children are identified, professionals must

When children are brought to mental health professionals because of problem behavior, screening for the presence of family violence is not routine.

then assess the needs of each individual to determine whether mental health intervention is necessary, and if so, which services are appropriate.

Identification

Children who live in battered women's shelters and children whose mothers seek legal or community-based assistance in coping with family violence constitute obvious subgroups of the larger population of children affected by domestic violence. Yet, these sources account for a small fraction of the more than three million children annually estimated to witness acts of domestic violence.³ Other sectors of this population are "hidden" in families that are similarly affected, but do not self-identify.⁴ Complicating the identification process is the veil of secrecy that surrounds violence in families. Children may experience feelings of shame, guilt, and divided loyalties to parents, as well as fear of repercussions, making it unlikely that they will disclose the violence to others. Battered mothers may also maintain secrecy, realistically fearing that disclosure may further jeopardize their safety and that of their children.

It is often difficult for professionals to identify children who witness domestic violence. School personnel, who spend signifi-

cant periods of time with children, may be unsure how to interpret problematic symptoms that children display. In addition, they may be unable to elicit or respond to disclosures about the child's home situation. Pediatricians may not be trained to screen for domestic violence, and rarely inquire about it.⁵ Even when children are brought to mental health professionals because of problem behavior, screening for the presence of family violence is not routine.⁶ Therefore, professionals often fail to detect that exposure to domestic violence is a contributing factor to the child's difficulties. Children who exhibit problematic behavior may receive inappropriate treatment because professionals are unaware of the cause of their symptoms. To respond properly to these children, personnel in schools, health and mental health care settings must develop and implement guidelines for screening and responses if a child discloses domestic violence. (For more information about the roles of health care professionals in identifying children exposed to domestic violence, see the article by Culross in this journal issue.)

Assessment

Once children who have witnessed domestic violence are identified, professionals must assess the child, the family, the living situation, and the nature of the events the child witnessed. Different recommendations may be appropriate depending upon the child's age and stage of development, the nature and duration of the child's symptoms and the impact on the child's functioning, the child's perceptions of and experiences with the violence, the child's ability to speak about the violence, the safety of the child's current environment, the presence of adults in the child's life who can be emotional resources, and the influence of the child's ethnicity and culture on defining the domestic violence and seeking help. The most commonly used assessment technique with children who have witnessed domestic violence is a focused clinical interview that explores the children's experiences with the violence,⁷ supplemented by data collection from various other sources, such as parents and teachers.

Not every child will need individual therapeutic intervention. Some children are resilient, possessing a wide range of coping



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skills.⁸ Children who can acknowledge their traumatic experiences by talking about them may require different forms of intervention from those who cannot.⁹ In addition, the presence of adult figures in children's lives who can cushion the child's experience of trauma and promote effective coping may reduce the need for formal mental health intervention.¹⁰

Mental Health Interventions

Mental health interventions¹¹ for children who witness violence have traditionally been available only in battered women's shelters or from agencies providing services to battered women. However, in recent years, more programs serving these children have been established in other venues, reflecting the growing recognition that children affected by domestic violence reside outside of shelters as well, and require service availability in a broad range of settings.¹²

Goals

A first goal of therapeutic intervention is promoting open discussion of the children's experiences. Many parents and professionals assume that it is better for the child not to dwell on the disturbing event(s), and to try to forget. The intensity of the child's terror, however, obviates the possibility of "forgetting."¹³ For many children, the process of retelling or reenacting a traumatic event in the safety of a therapeutic relationship is

in itself a healing experience, and a first step toward integrating the experience into their understanding of themselves and their world.¹⁴ In addition, the process of "breaking the silence" and speaking openly about the violent events serves to reduce the children's senses of isolation, which allows them to begin emotional healing.¹⁵

Second, therapists seek to help children understand and cope with their emotional responses to the violence, while promoting their acquisition of positive behavior patterns. Strategies include assisting children with understanding why their parents fight and helping them to realize that the fighting is not their fault, and that they are not responsible for managing it. With older children, groups may also discuss violence in personal relationships, and address anger management and the use of conflict-resolution skills.

Third, mental health interventions seek to reduce the symptoms the children are experiencing in response to the violence. Most approaches strive to help the child and the nonabusing parent to link the problematic symptoms to the exposure to violence, and to teach specific strategies for managing and decreasing symptoms. For example, if the child is suffering from insomnia and nightmares, an individual therapist might work with the parent and child to build soothing and comforting rituals into bedtime routines.

Finally, therapists work to help the family create a safe, stable, and nurturing environment for the child, because children cannot begin to recover from the effects of exposure to violence so long as the exposure continues.¹⁶ In situations where children continue to live in a dangerous environment, therapists strive to help the nonabusing parent obtain safety for herself and her children. In accomplishing this task, the therapist must often help the family address additional stressors, such as substance abuse or housing difficulties. In situations where the children and mother are not living with the batterer, mental health intervention strives to promote the children's feelings of safety and security. Therapists work with parents to help them understand the children's needs for consistent routines. With parental

sonal safety, and identification of feelings. Some of the groups are held in battered women's shelters, whereas others are based in mental health clinics or social service agencies. Some settings offer concurrent groups for the mothers.

Groups generally target children between the ages of 6 and 15, typically grouping children in age spans of two to three years.¹⁹ Groups are less likely to be helpful for preschoolers, who are typically more impulsive, less focused, and less likely to use peer relationships to cope with stressful issues than are older children. (Individual interventions with strong parent counseling components are typically recommended for these younger children.) Regardless of age, groups are typically not appropriate for children who may be more severely traumatized, because such children have more complex needs and are probably better served by individual treatment. For example, children who have witnessed fatal domestic violence and are coping not only with the trauma of the events, but also with issues of bereavement, fall into this category.²⁰

Stabilizing the child in a safe home situation is an important component of successful therapy, as is forging a positive bond between the child and the nonviolent caregiver.

permission, treatment may also include consultation with teachers or child care providers in order to develop consistent strategies for the classroom or day-care setting. In addition, therapists attempt to strengthen those emotional supports potentially available to the children, and work to reinforce the bond between the child and the nonabusing parent.¹⁰

Therapy Approaches

Children who witness domestic violence may be seen in group or individual therapy. Empirical studies investigating the outcomes of these interventions are extremely limited; no controlled studies have been published. Follow-up interviews with participants, however, suggest that the therapeutic interventions have positive effects.¹⁷

Group Interventions

The most widely described intervention for children who have witnessed domestic violence is group counseling.¹⁸ Most of these groups are time-limited, usually between 6 and 10 weeks, and use a specific psychoeducational curriculum that provides structure for discussions about family violence, per-

Group treatment can assist children and adolescents with important developmental tasks. Groups break the isolation and enable children to tell their stories in the presence of others who closely identify with the experience.²¹ For adolescents, groups are particularly appropriate, given the importance of the peer group for defining behavior norms. Adolescent groups may also focus on violence in dating relationships, sexism, and abuse of power. These issues are quite relevant to adolescents, whose developmental tasks include establishing intimate relationships and acquiring a sense of personal identity as they approach adulthood. (For more information on programs for adolescents that address domestic violence issues, see the article by Wolfe and Jaffe in this journal issue.)

A subgroup of children who witness domestic violence are also living through their parents' high-conflict divorce.²² Many such children feel trapped in the middle of intense and prolonged interparental conflict and experience confusing feelings of loyalty and responsibility. The goals addressed above are appropriate for these children as well. Additionally, groups can help these children to understand family members' roles in

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the separation and to develop their own perspectives on the conflict.

Individual Interventions

Very little has been written about theoretical models and therapeutic approaches for individual treatment of children affected by domestic violence.²³ Some clinicians have adapted models developed to treat related phenomena, such as posttraumatic stress disorder (PTSD) in children.²⁴ Not all children exposed to domestic violence display symptoms meeting the criteria for diagnosis of PTSD,²⁵ but many similarities exist. In both sets of circumstances, the therapist seeks to stabilize the child's life situation, to help the child integrate the experiences of the violent event(s) in an adaptive manner, and to work with the child to manage the symptoms that resulted from the trauma.

The Child Witness to Violence Project at Boston Medical Center has developed an individual model for young children that is adapted from models for treating PTSD.²⁶ In this treatment, children are encouraged to discuss the traumatic events they have experienced, to identify feelings, and to learn to manage symptoms. In addition, this program involves the children's teachers and other caregivers in the treatment process, at assessment and intervention phases. This program is one of the oldest outpatient (and nonshelter-based) programs in the country, and its experience has encouraged the funding of other outpatient programs based in a

range of different settings in Massachusetts. Although it has not included an evaluation component to date, project directors have recently obtained funding to proceed with such evaluation.

The Child Trauma Research Project at San Francisco General Hospital has built upon another therapeutic model. It employs a psychodynamic approach to treat preschooler-mother pairs affected by domestic violence.²⁷ This therapy program strives to help the children and mothers deal with the effects of the violence, while strengthening their abilities to function as a healthy family unit. Early results of an evaluation component indicate improvement in mother-child relationships, improvement in individual child functioning (particularly with learning readiness), and a decrease in children's symptoms.

Challenges

Providers must confront a variety of challenges as they seek to serve children who have witnessed domestic violence. These include working with the children's family members, responding to the children's intense emotional experiences, and addressing suspicions and evidence of concurrent abuse of the children by one or both parents.

Working with Families

Regardless of setting or modality of treatment, most descriptions of treatment of children who witness domestic violence stress

the importance of involving parents. Stabilizing the child in a safe home situation is an important component of successful therapy, as is forging a positive bond between the child and the nonviolent caregiver.

Therapists can help nonabusive parents recognize the impact of violence on their children, can increase the stability and routine in their children's lives, and can devise strategies to help the children cope.²⁸ In addition, therapists can assist parents in learning how to talk with their children about the violent events. Finally, therapists may serve as advocates, assisting parents in securing a

Professionals in the mental health, health, and educational fields must consider whether children who come to their attention for psychological, learning, or developmental problems might be responding to domestic violence exposure.

range of services: legal assistance, housing, health care, and appropriate school placement. Although advocacy of this type is a less traditional therapeutic function, it is often essential to helping families affected by domestic violence stabilize their lives sufficiently so that family members can benefit from direct treatment.

In general, involving the parent who perpetrates domestic violence in any facet of the child's therapy is complicated. There are some perpetrators who, despite their conduct vis-à-vis the other parent, will have an ongoing relationship with the child, as in visitation or shared custody. In these cases, it may be in the child's interest for the therapist to involve that parent in the child's treatment. For example, the therapist, meeting separately with this parent (so that the battered parent need not encounter him in sessions), may provide guidance to him about the child's needs for consistent and reassuring daily routines, how to react to the child's complex feelings toward him, and appropriate (nonaggressive) techniques for managing the child's behavior. It is important, in such situations, that a therapist treating the child not attempt to serve the needs of all parties (for example, the

batterer, the abused parent, and the child), because doing so may lead to conflicts of interest.²⁹

Meeting Children's Complex Emotional Needs

In some respects, children who witness domestic violence have unique emotional needs. Typically, children turn to their parents for protection in times of stress or fear. Research indicates that if children have access to a parent, they are more resilient in response to trauma than are children who do not.^{8,10} Children exposed to community-based violence, or trauma caused by an accident, often have access to one or both parent(s) for psychological support. By contrast, children who witness domestic violence may not have such emotional refuge—the perpetrating parent is unsafe and the battered parent may be emotionally unavailable because of her own trauma.³⁰ Furthermore, these children suffer cumulative losses when they must leave their home to seek safety.

In addition, children in a family affected by domestic violence often have complicated, ambivalent, and overwhelming feelings toward the parent who perpetrates the violence. Victimized mothers may find it difficult to tolerate their children's expressions of sadness and loss for the abusive parent. Therapy can provide a safe haven where children can express these emotions.

Addressing the Possibility of Concurrent Child Abuse or Neglect

There is a higher incidence of child abuse and neglect in families characterized by domestic violence than in the general population.³¹ Therefore, therapists treating children who witness domestic violence must assess whether there has been, or is likely to be, direct abuse of the child by either parent. In addition, therapists are mandatory reporters of child abuse to child protective services (CPS). Thus, therapists must be familiar with the specifics of their state reporting laws, and must be prepared to work with CPS if an investigation of suspected abuse proceeds.²⁹ These legal obligations can jeopardize the therapeutic relationship and raise challenging ethical issues.²⁹ (See the article by Findlater and Kelly in this journal issue for an analysis of the relationship between CPS and children exposed to domestic violence.

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See also the articles by Matthews and by Lemon in this journal issue, for analyses of relevant federal and state laws, and of the legal system's responses to these children's needs, respectively.)

Funding Mental Health Services

One source of funding for mental health services is health insurance. The U.S. Census Bureau estimates that 11.3 million children in this country are uninsured.³² Uninsured children may have a difficult time accessing mental health care. Even when a family has private or public health insurance, mental health coverage is likely to be inadequate. Families may be forced to choose from a fixed list of providers, without regard for the provider's experience or expertise with domestic violence or trauma. Services usually are capped at a certain number of sessions, often a number that is inadequate for the complexities that domestic violence presents. Insurance policies may not cover services such as a therapist's consultation with the child's school or contacts with pediatricians, attorneys, or other providers involved with the family. Finally, insurers typically will not cover services provided in the absence of a diagnosable mental health disorder. Thus, children who are suffering, but whose symptoms do not fit into a defined diagnostic category, may not be eligible for reimbursement.

Public and private grants to particular agencies constitute another source of funding for mental health services provided to children who witness domestic violence. In recent years, there has been increasing federal awareness about the needs of families affected by domestic violence, leading to passage and funding of the Victims of Crime Act and the Violence Against Women Act. Some states, such as Massachusetts, have also invested substantially in services to this population. The disadvantage of grant funding is that it is not a secure source. Programs must operate with continual uncertainty about the availability of ongoing funding, and thus may be compromised in long-term planning. (For more information about federal policies regarding domestic violence, see the article by Matthews in this journal issue.)

Conclusions and Recommendations

The costs to children and to society of children's exposure to domestic violence are enormous. The tentative good news is that there is growing recognition of the importance of reaching out to these hidden victims of domestic violence. To reach these hidden victims, however, all agencies, institutions, and providers who serve children (particularly schools and pediatric practices) must increase efforts to identify children who are exposed to domestic violence.

Identification guidelines must be developed that balance these children's need to be identified with family privacy. In addition, professionals in the mental health, health, and educational fields must consider whether children who come to their attention for psychological, learning, or developmental problems might be responding to domestic violence exposure. Those who serve the needs of battered women must make appropriate referrals so that the women's children can be assessed and treated. Building the expertise necessary for professionals to recognize when children have been exposed to domestic violence will require training for service providers.

Expansion of service-delivery locations and networks is necessary, in that available services are not sufficient to meet the needs of the population. If professionals succeed in identifying greater numbers of children affected by domestic violence, the need for such expansion will be even more pressing. Mental health providers treating children exposed to domestic violence must learn how to work with this population, developing expertise in child development and crisis intervention, and learning about the effects of trauma on individuals and appropriate assessment and treatment approaches.

Evaluations of treatment programs will contribute important information about the

standards of good treatment, the differential use of individual or group intervention, the effect of age on the type of service needed, successful parent-involvement strategies, and the long-term benefits of treatment. Long-term follow-up data are important as well in light of research findings indicating that the effects of witnessing domestic violence in childhood extend into adulthood. In addition, clinicians and researchers must continue their efforts to develop and evaluate assessment techniques helpful in determining how best to meet the individual needs of these children.

Furthermore, the establishment of a data collection system will allow service providers and agencies to pool information about the children they serve, how they are serving them, and the results of intervention. In this way, the field can significantly improve its knowledge base about basic epidemiological issues, as well as the availability, use, and success of various intervention approaches.

Finally, increased funds are needed from both the public and private sectors to create and maintain the expertise, the services, and the data necessary to help these children. It is hoped that public attention to the plight of children who witness domestic violence will lead to greater commitment of financial resources.

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