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Domestic Violence: How to Treat the Unseen Victims

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Domestic Violence: How to Treat the Unseen Victims

by

Sarah A. Callahan, B.S.W.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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Michael G. Chovanec, Ph.D., LICSW (Chair)
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master’s thesis nor a dissertation.
DOMESTIC VIOLENCE HOW TO TREAT THE UNSEEN VICTIMS

Abstract

Domestic violence is something that impacts families worldwide. One in three women in the US will experience domestic violence in their lifetime (Center for Disease Control and Prevention, 2012); given this statistic, children will inadvertently be exposed to domestic violence as a result. Young children, whom are likely in the home with their parents, are highly vulnerable to domestic violence exposure, and the impacts that it has on mental health functioning. This qualitative research project focused on the question “What are the best methods of practice for working with children aged 2-6 who have been exposed to domestic violence and are experiencing mental health complications?” This research was done utilizing a semi-structured interview with professionals who work with children and carry a caseload of 50% or more of children exposed to domestic violence. Findings include overall descriptions of symptomology due to domestic violence exposure; the importance of recognizing variations of symptomology based on the circumstances surrounding the child’s exposure; age appropriate treatment recommendations, consistency being central in treatment, and recommended wrap around services for the family; and the need for professionals to get the big picture and assess for domestic violence exposure to reduce misdiagnosis. Implications from this study include the need for agency supervisor’s to monitor turnover rates and consistency of service provided, the need for funding of agencies which provide wrap around support for families experiencing domestic violence, and the importance of professional consultation and in-depth assessment in order to reduce misdiagnosis.
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Delilah is a 4-year-old little girl, struggling in preschool. She goes from content to crying in a split second, and has little relationship connections with her peers or teachers. She is non-compliant with her preschool teachers’ rules, and doesn’t respond to direction when given, often becoming extremely defiant or letting her body go completely limp (like a ragdoll) when redirected by an adult. Her relationships with other children are lined with conflict, in which she often hits and even occasionally bites other children. She has been referred to Early Intervention Services for evaluation for possible Oppositional Defiant Disorder, and to rule out other developmental disorders. Upon initial interview with Delilah's mother, the practitioner finds out that Delilah is struggling at home as well. Delilah's mother is currently seeking an Order for Protection against the father, for repeated acts of domestic violence. Although mother claims Delilah has never witnessed the abuse between mother and father, she admits on occasion to finding Delilah cowering in the corner after a yelling match occurred between parents. Mother reports that father had spanked Delilah on more than one occasion. Mother is unsure how to help her child cope with the current situation at home and acknowledges her child is additionally struggling at preschool as well. (Composite of collection of case example(s) - from Author)

Domestic violence has been prevalent in our society for centuries, dating back to biblical times (Kramer, 1990). The issue of domestic violence is a world-wide affair. Specific to the United States, a survey in 2010 showed that “1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime” (Center for Disease Control and Prevention, 2012). In 1994, domestic violence finally got much needed legal recognition in the U.S, in the form of the Violence Against Women Act (VAWA) which set “increases [in] criminal penalties and provides grants to
address rape, sexual assault, domestic abuse and other gender-related violence” (Heger, 2000).

In light of this act, many resources and gains have been made to address the issues of safety for families, including stricter enforcement of Orders for Protections (OFPs), harsher punishments for abusers, and funding for safe havens for those leaving domestic violence circumstances.

Domestic violence is not something that only impacts the direct victim, it leaves lasting marks on the entire family system, especially on the children who are exposed to the violence yet are often powerless to intervene or seek help on their own.

The unseen victims of domestic violence are the children who are inadvertently exposed. In a study done by Fusco & Fantuzzo (2009) domestic violence calls were tracked over a one year period; the data showed that children were frequently present and impacted by exposure to violence. Of the 1581 reports, that data showed 43% of domestic violence events in that specific county reported children home during the altercation. Of that population of children at home during the domestic violence event, 95% were reported to have experienced at least one sensory exposure, and 60% of that group additionally reported both hearing and seeing the domestic violence occur. The study then went on to report child involvement in the domestic violence event, stating that almost 75% of the children present at the domestic violence event were in some way involved (being a part of the precipitating events, calling for help, or being physically involved) (Fusco & Fantuzzo, 2009). This study demonstrates the magnitude of domestic violence events that involve children, and how it is an area for social concern.

Domestic violence or often referred to as intimate partner violence or domestic abuse, can be present in more than just a physical form. From the National Coalition against Domestic Violence, this definition is given:
“Domestic violence is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner’s consistent efforts to maintain power and control over the other.” (NCADV website)

Under the umbrella of domestic violence there are a few categories: physical abuse, sexual abuse, emotional abuse, and a newer added category financial abuse (Yoo & Huang, 2013).

Relating to the profession of social work, domestic violence is an issue that many practitioners grapple with daily. From advocacy social workers who work with victims to safety plan, to group work social workers who conduct domestic violence education/intervention groups, even to mental health practitioners (LICSWs) who may provide therapy for the victims and children who are exposed to domestic violence trauma; social workers have their fingers on the pulse of this issue. In social work it is important for the professional to utilize the person in the environment (PIE) perspective (Kondrat, 2013), in order to assess, direct, and implement the work with clients. In dealing with children who have experienced exposure to domestic violence in the home, it is important to realize that while they might not be the direct victims of the abuse, they suffer from exposure in many other indirect ways: witnessing the trauma of one of their parents being physically assaulted by the other; having to fear for safety of their parent(s) or for themselves; and/or having their own needs go unmet (either physically or emotionally) due to the crisis of abuse in the family.

At all ages, and as early as in utero, children can be impacted by the effects of domestic violence exposure. Many studies have looked at the impacts of domestic violence exposure on children in all stages of life: during pregnancy; infancy; early childhood; middle childhood; and adolescents. Therefore, this current qualitative study sought to answer the question “What are
the best practices for Social Workers treating children exposed to the trauma of domestic violence?”. This study obtained research data from the perspectives of those who work the closest to the issues of domestic violence and childhood exposure: children’s mental health professionals.
Literature Review

This study set out to explore the impacts of domestic violence exposure on children’s mental health. In the review of studies already completed surrounding domestic violence and children, this study explored domestic violence exposure during pregnancy and infancy. Secondly this study reviewed literature on domestic violence in preschool through teenage years. Additionally, the study reviewed literature related to domestic violence exposure and impacts on adult functioning. Lastly this study reviewed literature on domestic violence considerations for prevention and intervention.

Infancy

Studies have shown that as early as in utero, impacts on domestic violence exposure can be found relating to the health and development of the unborn baby. A study conducted through a systematic literature review (inclusion of 70 articles) related to domestic violence and pregnancy found that maternal and fetal impacts of domestic violence on health outcomes are prevalent, including for the fetus, premature birth, low birth weight, possible need for intensive care upon birth and in worst case scenarios even infant death (McMahon & Armstrong, 2012). From this study, it was found that women exposed to domestic violence often gave birth prematurely due to physical complications from assault, and/or emotional stressors of living with an abusive partner. A limitation of the McMahon & Armstrong study is that the time frame of selected literature reviewed was a 20-year frame, from 1990 to 2010, and some of the research included from those studies may be outdated.

A second study taking the finding of McMahon & Armstrong a step further into infancy, was done by Carpenter & Stacks (2009) through a qualitative systematic review of 126 research studies. This literature review uncovered impacts of domestic violence exposure on brain
development in infants. The study found that that due to elevated stress levels in infants and impacts of domestic violence on maternal mental health (therefore impacting the attachment development of the infant to mother) brain size and function of brain may be smaller compared to those infants who are not exposed to domestic violence. (Carpenter & Stacks, 2009)

Herman-Smith (2013) presents information from a theoretical framework on brain research that attempts to theorize how exposure to domestic violence can cause dysregulation with stress hormones in the brain in infants. In theory it states that when dysregulation with stress hormones occurs, this leads to alteration of neural circuits- resulting in the infant being overly sensitive to stressful events. The article also highlights the relationship between domestic violence, hormonal flooding in infancy, and the link that flooding has in relationship to genetic vulnerabilities being activated. This literature is a theoretical framework, however, and while it serves to explain theories, and cites research to support those theories, it does not provide concrete/direct research evidence to prove those theories. More research needs to be undertaken in this area of neural science and the environmental impacts of domestic violence exposure. (Herman-Smith, 2013)

From the above literature, it is evident that domestic violence has impacts on the unborn child and infant (McMahon & Armstrong, 2012). Many times, the secondary impact of the abused mother’s distress takes its toll as she may not be able to be provide emotionally for the infant which can have detrimental effects on the baby’s development (Carpenter & Stacks, 2009). Further studies need to be undertaken to examine the impacts of domestic violence on early infancy. Short term as well as longitudinal studies would be helpful, in order to track exposure, current impacts, and impacts later in life.
Preschool through Teenage Years

Multiple studies have been conducted examining effects of domestic violence exposure on children age 4-17 (Yoo & Huang (2013); Meltzer et al. (2009); de la Vega et al., 2011); Hunt et al., 2011). Results of these studies vary, but all typically show some sort of detrimental impacts to those who are exposed to domestic violence, be that mental health issues or behavioral problems. Some of the mental health impacts for children with domestic violence exposure uncovered in the research discussed in this section include childhood depression, anxiety, Oppositional Defiant Disorder, Conduct Disorder, attachment issues with caregivers and more. The following studies discuss findings related to domestic violence exposure in children age 4-17.

Yoo & Huang’s (2013) research consisted of a longitudinal study with a sample size of 1,234 of mothers, following their family starting at age one of the child thru to age five years old. This study found a significant correlation between mothers’ who experienced domestic violence when their child was one year old, and behavioral issues with the child presenting at age five years old in the domains of children’s aggressive behavioral problems (r=.12, p<.001), children’s delinquent behavior problems (r=.10, p<.001), children’s anxious-depressed behavior problems (r=.09, p<.01) and children’s withdrawn behavior problems (r=.04, p<.05). This study was a secondary data analysis from the Fragile Families and Child Wellbeing Study commencing in 1998. A limitation of this study is that the measurement for domestic violence exposure may not be accurate. The study derived its measure from two responses on a three point scale to the question how often did you experience the following (insert forms of domestic abuse)…” a) never, b) sometimes c) often; taking responses b) sometimes and c) often as their measure for indication of domestic violence exposure. (Yoo & Huang, 2013)
Meltzer et al. (2009) did a study on children aged 5-16 with an initial stratified sample size of 12,354 children systematically sampled from 426 different zip codes in Great Britain. Of the initial sample, 340 children (4.3%) had witnessed severe domestic violence according to parental reports. This study found “when biographic, socio-demographic, socio-economic variables were added into a multivariable logistic regression model to investigate the independent correlates of conduct disorder, witnessing domestic violence remained significantly associated with increased odds of having conduct disorder (OR=1.78, 95% CI=1.79-3.92, P<0.001).” This would align itself with the previously discussed study by Yoo & Huang (2013) results of children’s exposure to domestic violence correlating to later behavioral issues. Meltzer et al (2009) results could be more easily generalize as the study used a sample selection of participants systematically selected from each of the 426 zip codes of Great Britain. A limitation of the study was that there was no clear definition of “severe” domestic violence by the researcher, and instead the definition was left up to interpretation of the victim. (Meltzer et al., 2009)

Another study done by de la Vega et al. (2011) demonstrated impacts of psychological maltreatment on 168 children aged 4-17 whose mothers were seeking refuge in a domestic violence shelter. The study found the types of emotional abuse like spurring and denying emotional responsiveness, had a correlation between an increased likelihood of internalizing psychopathology for the children impacted, stating that “spurning is associated with increase in Mood disorders (adjusted OR=9.99)...denying emotional responsiveness increases the risk of suffering from major depression (adjusted OR=7.11)” (*significant OR (0.05, with Bonferroni-Finner correlation) (de la Vega et al., 2011). Internalizing psychopathology is a term used to define a broad range of conditions characterized by negative emotion (i.e. depression, anxiety,
and phobias) (Krueger & Markon, 2006). Additionally, this study also noted that denying emotional responsiveness resulted in impairment in emotional development for children impacted. This study demonstrates how emotional abuse can impact children in their psychological development. Limits of this study include the sample population being derived from mothers seeking refuge from domestic violence at an agency, not being able to be representative of the general population, as well as the wide age range of children in the sample. (de la Vega et al., 2011)

Lastly, Hunt et al. (2011) produced a study with a sample size 257 clients who received services from the outpatient Mental Health Program in California, and consisted of African-American children aged 8-17. In this study Hunt et al. found a positive correlation between exposure to domestic violence and increased rates of Post-Traumatic Stress Disorder (PTSD) (p = .027, p < .001). In this study it was additionally noted that females in comparison to males, scored an average of 6 points higher on their severity scales, thus significantly being associated at higher rates with PTSD symptoms. This study demonstrates how exposure to violence can have severe impacts on children’s mental health. The study, however, focused a sample of African-American youth, and therefore not be representative of the general population or across cultures. (Hunt et al., 2011)

From these studies, one can derive that domestic violence exposure does have negative impacts on children specifically in mental health and behavioral issues. In order to get concrete answers to the impacts on domestic violence exposure on children, more studies need to be conducted with better defined measures of indication of domestic violence exposure, wider sample populations, and longitudinal studies to see the impacts/ changes over time. In addition to the need for further research on the impacts of domestic violence exposure, studies should also
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take place on methods of treatment and interventions services for children and families who are coping with the trauma of domestic violence exposure.

**Impacts on Adult Functioning**

Research has been conducted to show impacts of witnessing domestic violence as a child and how it can adversely impact adult functioning utilizing the “Adverse Childhood Experiences Study” also known as the ACE study (Dube, et al, 2002; Whitfield, et al., 2003). The ACE study was a longitudinal study out of San Diego which began recruitment in 1995-1997, and followed participants’ long term to study health outcomes. From a study done by Dube, et al. (2002) which utilized the ACE data, a sample of 17,421 participants (mean age of 55 years old for women and 73% white, and mean age of 58 years old for men and 76% white) who sought medical care at the Health Appraisal Center in San Diego, CA., results showed adverse impacts on adults who witness domestic violence during childhood. The results of the study showed that people who witnessed pushing, grabbing or slapping of their mother during childhood “very often” reported alcoholism as an adult as 15.9% of the sample; 33% of the sample exposed to domestic violence as a child admitted to illicit drug use as an adult; 3.3% of the group admitted to IV drug use in adulthood; and 45.1% of the sample reported having a depressed affect as an adult (Dube, et al, 2002). The results from this study may not be 100% accurate as the methodology consisted of client administered surveys which were dependent on client’s accurate self-reporting (often times clients under report) and the accurate recollection of domestic violence exposure during childhood (differential recall effect); as stated by the author of the article, “therefore, although our findings are strong, they probably underestimate the true strength of the relations of witnessing IPV to ACEs” (Dube, et al., p. 14, 2002).

In another study done by Whitfield et al. (2003) the impacts of domestic violence
exposure in childhood are examined through the same ACEs study mentioned above, to look for correlations of those children growing up into adults who then perpetrate or become victims of domestic violence. From the study it states that “witnessing domestic violence increased these risks [domestic violence victimization (for women) and perpetration (for men)] approximately 2-fold for women and men.” (Whitefield et al., p. 176, 2003). This study shows that witnessing domestic violence as a child can have adverse effects on adulthood in that the child may continue to perpetuate or be a victim in the domestic violence. Additionally findings from this study state that “children exposed to violence are at an increased risk of IPV later in life and that the risk is cumulative based on the number exposures” (Whitefield et al., p. 181, 2003), meaning that the greater the frequency of exposure, the more likely the child is to become a victim or perpetrator as an adult. These studies conducted with ACEs data highlight the impacts of domestic violence exposure on children and how it can adversely impact adult functioning.

**Prevention**

Much of the literature related to domestic violence exposure and its impacts on children speaks to the nature of lack of services or screenings for domestic violence taking place in the home (i.e. screenings in schools, clinics, emergency rooms, common places victims might be making connection to services) (McMahon & Armstrong (2012); Yoo & Huang (2013); Carpenter & Stacks (2009)). An example of this is from Carpenter & Stack work stating that “...Less than half (43.1%) of child welfare agencies report that they assess 100% of all of the families who are referred to them and that most referrals take place at investigation” showing that many child welfare agencies are not implementing screenings across the board. This is an area that is in need of attention and expansion if we seek to reduce impacts of domestic violence on families and especially on children. In order to do so, efforts must be made to increase early
detection and intervention. Screenings for domestic violence should be taking place in social services settings and health care settings, in order to best detect and intervene early.

Many professionals are recognizing the need for intra-professional disciplines to work together in efforts to reduce domestic violence. This means law enforcement, child protection, the medical field and social services. Simple standardized questions that clinicians/service providers are trained to routinely asked during doctor visits or social service interactions regarding safety/abuse, or a short survey that the client could complete—similar to that of the PHQ-9 Quick Depression Assessment (complete with questions about safety/abuse with likert scale response rating)—would be simple and short ways to get the open dialogue going about domestic violence in the home. Lack of screenings for domestic violence being implemented by health and social work professionals during pregnancy, was an area of concern and noted need for improvement in the McMahon & Armstrong study (2012). From the Yoo & Huang (2013) research, it was recommended that early social work intervention that focuses on maternal mental health should be made, and targets for screening in both parent and child services are needed in order to avoid future behavioral issues for the young child.

There are studies that show much cause for concern in identifying domestic violence in child protective services. Carpenter & Stacks (2009) literature review work demonstrated that screening for domestic violence in child protective service agencies was lacking. It stated that less than 43% of child welfare agencies were conducting screenings for domestic violence with every referral for every child welfare assessment case that is referred to their agency. Further, many agencies reported that domestic violence screenings took place at the point of child welfare investigations, meaning that cases that were referred that did not meet criteria for investigation were falling through the cracks. While this information came from a literature review, future
research should be conducted to investigate CPS screenings for domestic violence, especially
given the weight of impacts on exposure to domestic violence can have on children. (Carpenter
& Stacks, 2009)

**Intervention**

In addition to the screenings for abuse being adequately conducted, social service
providers need to recognize the importance of working with the family and children and finding
effective treatment modalities to help families cope, heal, and move forward in their lives after
exposure to domestic violence. In a study focused on clinicians responding to domestic violence
interventions one major theme was uncovered, developing effective working practices when
working with families exposed to domestic violence. In this theme, the practitioners discussed
the importance of placing less emphasis on clerical works and more focus on the family and
helping them cope (Clarke & Wydall, 2015). The Clarke & Wydall (2015) study was a
qualitative study of focus groups of 54 professionals from multiple social service agencies who
collaborated on domestic violence services. This research points out that many social service
providers from the focus groups felt that there is an over emphasis on case records and
paperwork, instead of focusing on the needs of the child in front of them. A second theme from
the focus group was uncovered amongst practitioners “If practitioners are to successfully balance
the needs of children with those of adult victims and perpetrators, then they need to have an
understanding and appreciation of children’s actual experiences in this context.” (Clarke &
Wydall, 2015). This study aligns itself with the notation for collaborations between agencies in
order to make needed improvements in service provided. The study also suggests (aligning itself
with Carpenter & Stacks (2009)) that more services need to be in place for children who do not
meet the criteria of child protective services, but still have been exposed to domestic violence.
We need to make an effort for social service referrals to be made proactively, instead of reactively in order to combat domestic violence.

**Treatment**

Current treatment modalities for children who are exposed to domestic violence which show evidence of effectiveness include child-parent psychotherapy and trauma focused cognitive behavioral therapy (Lieberman et al., 2011). Therapies that view importance of the child’s secure attachment are becoming central in the treatment of children exposed to domestic violence, as stated in the following: “securely attached infants are better able to modulate their physiological stress responses when compared to infants in insecure attachment relationships, and disorganized attached is associated with even greater psychological dysregulation” (Gunnar & Cheatham, 2003; Gunnar & Quevedo, 2007 cited in Lieberman et al., 2011). Locally, in Minneapolis there are multiple agencies that offer services for children suffering from trauma of domestic violence exposure incorporating the above evidence based practices. Such agencies include places like *The Family Partnership*, whose program goals include “respond(ing) with programs and initiatives squarely focused on reducing and preventing poverty... and healing the damaging effects of poverty and adverse experiences on children, youth, and families.” (The Family Partnership, 2017). This program does this through individual therapy, family therapy, child play therapy, and a therapeutic preschool. A program that works from the lens of Trauma Informed Therapy both locally and nationally is called *The Domestic Abuse Project (DAP)*. This particular program offers services for men, women and children (both the victims of abuse, as well as the perpetrators) serving the Twin Cities “with innovative and effective programming to end the inter-generational cycle of domestic violence. We have made it our mission to build communities free from violence by providing holistic healing for every member of the family.”
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( Domestic Abuse Project, 2017). While the use of therapy for young children appears most recommended, the use of psychopharmacological treatment for children under age 5 is not currently recommended. (Lieberman et al., 2011) Instead, literature suggest trauma informed therapies as being considered current best practice for young children exposed to domestic violence for example: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief (TG-CBT); Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP); Attachment, Self-Regulation, and Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth; Child-Parent Psychotherapy (CPP); and Parent-Child Interaction Therapy (PCIT) (de Arellano, et al., 2008).

Summary

Domestic violence exposure impacts can be wide ranging depending on type of domestic violence (verbal, physical, etc), the intensity of exposure, and age of the child being exposed. The research, however, undoubtedly shows that there are many adverse implications of domestic violence exposure on children which even for some follows them into adulthood. From impacts on pregnancy including premature birth, low birth weight, possible need for intensive care upon birth and infant death (McMahon & Armstrong, 2012), to impacts on infancy such as reduced brain size and function of brain in comparison to those infants who are not exposed to domestic violence (Carpenter & Stacks, 2009); the impacts can be devastating. In later stages of life from preschool on up to teenage years, exposure to domestic violence can lead to Conduct Disorder, Oppositional Defiant Disorder, depression, anxiety, attachment issues, and much more. (Yoo & Huang, 2013; Meltzer et al., 2009, de la Vega et al., 2011). Even in the lives of adults, the impact of domestic violence exposure in childhood has been found to be correlated to negative
health outcomes such as substance abuse, depressed affect, and engagement in victimization or perpetration of domestic violence as discovered from the ACES research. (Dube, et al. 2002 & Whitfield, et al., 2003)

More research needs to be conducted on the specific outcomes of children who are exposed to domestic violence, as well as preventative services that social service providers can offer. Because there are so many adverse consequences of children being exposed to domestic violence, it begs the question be asked, how can we as professionals best treat those unseen victims of domestic violence, the children who have been exposed to trauma. This current study conducted focuses on the research question “What are the best methods of practice for working with children aged 2-6 who have been exposed to domestic violence and are experiencing mental health complications?” seeking the answer from the professional’s view, who works with domestic violence through crisis intervention daily.
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Conceptual Framework

Ecological Framework

The theoretical framework is used to guide the research and look for findings through a specific lens. The theoretical framework that was used in this study is the Ecological Framework. This framework examines the micro, meso and macro aspects of the “person in the environment”. It recognizes that people exist in relationship to other systems at work, and examines those systems and their impacts on the person. (Gitterman & Germain, 2008) A child who is exposed to the trauma of exposure to domestic abuse occurring in the home, is not only a part of the home system, but many larger systems which impact the experiences and treatment approach with said child.

Micro. The micro system is the smallest system of social work analysis. According to the Social Work Dictionary (Barker, 2014) micro practice is “the term used by social workers to identify professional activities that are designed to help solve the problems faced primarily by individuals, families, and small groups. Usually micro practice focuses on direct intervention on a case-by-case basis or in a clinical setting”. In this system things that are examined include the client- their relationships in a family, their racial status, economic status, age, gender, sexual orientation, etc. In this system is where domestic violence is known to reside, within the homes of intimate partners and their families.

A child exposed to domestic violence is existing in a home or family relationship. That child is a part of a larger family; a son or daughter; brother or sister; grandchild or cousin. The relationships that exist in that family are a part of the micro system.

Mezzo. The mezzo practice is the “mid-range” level of analysis falling between Micro and Macro. According to Baker (2014) mezzo practice is “Social work practice primarily with
families and small groups. Important activities at this level include facilitating communication, mediation, and negotiation; education; and bringing people together.” This level analyzes relationships in the community on a more organizational level that impact the client. Things that can be examined are a client’s accessibility to resources, education, health services, their membership in a tribe or organization, and more.

The same child who is exposed to domestic violence in the home, is surrounded by community, neighbors, businesses and social services. That child may belong to a clinic where s/he is seen routinely for well child checks. The child may be involved in therapy at the local counseling center where s/he receives services for ADHD diagnosis. The same child might be attending an early education program in which s/he is learning the ABC’s. All of these systems impact the experience of the child; the rules which govern interactions of the child and his/her family in order to access services, what the child and family can expect when accessing services, what responsibilities the agencies have towards the healthy development of this child and healthy family growth - all of these are domains that the mesosystem examines.

**Macro.** *Macro* level social work analyzes the transfer of goods and services over the larger populations. According to the *Social Work Dictionary* (Baker, 2014) macro practice is “Social work practice aimed at bringing about improvements and changes in the general society. Such activities include some types of political action, community organization, public education campaigning, and the administration of broad-based social services agencies or public welfare departments”. Who are the haves and have nots, and why? What are the policies and laws that are feeding the current status quo of a society? These questions are analyzed on a societal level to uncover impacts on the client.

The same child exposed to domestic abuse in the home is a member of a larger society.
In this system one must consider how access to resources impacts the child in his/ her environment. Social services like quality housing, financial assistance to families experiencing crisis and poverty, quality access to education and childcare and safety considerations for the child and family are all things that must be examined in the *Macro* system.

**Utilization of Ecological Framework in this Research**

All of these systems, the *Micro, Meso* and *Macro*, impact how a child exposed to domestic violence in the home can process, integrate, and heal from the trauma. In using the Ecological Framework in this research, the *Micro* level was explored relating to what risk factors/ resiliency factors are know which impact a child’s mental health in response to the trauma of domestic violence exposure. On the *Meso* level the research explored what agencies and communities are currently doing to impact treatment of this kind of trauma. On the *Macro* level the research sought to outline what resources should be made available to help prevention and intervention on behalf of children experiencing trauma from domestic violence exposure.
Methodology

Research Design

The purpose of this study was to further explore treatment methods for working with children who have been exposed to the trauma of domestic violence. The study sought to answer the research questions: “What are the best methods of practice for working with children aged 2-6 who have been exposed to domestic violence and are experiencing mental health complications?” This study consisted of a qualitative design with an exploratory nature, in which the research design of qualitative interviews with professionals will be used. A semi-structured survey administered by the researcher with participants who are children’s mental health professionals occurred, was transcribed, and then was analyzed for findings. This study focused on children age 5 and under, and the impacts of domestic violence exposure on mental health.

Sample

A snowball sampling technique was implemented to obtain a sample of children’s mental health workers interested in participating in this research. Committee members on this research project were asked to supply 2-3 potential leads to practitioners eligible for participation in this study. In addition, the researcher contacted known contacts within the agencies of Fraser and The Family Partnership for potential participants and referrals. Criteria to participate in this research study consisted of a minimum of Master’s degree and Licensure in Mental Health Services (i.e. MSW, LICSW, LMFT, LPC, LPCC, or LADC). The participant must have been working in the area of children’s mental health services with one year of practice experience working with children and families exposed to domestic violence. Additionally the participant must be working at least 75% (carrying a caseload of 75% or more) of the time with children
who have experienced trauma aged 2-6.

**Protection of Human Subjects**

The interviews were administered on a voluntary basis. The interviews took place in a private setting of the participant’s choice, either in a private space at the employment agency of the participant, or in an outside public space that will be reserved by the researcher and ensures confidentiality (i.e. university meeting room, or public library meeting room). Informed consent letters were distributed to participants prior to the administration of the interview. Confidentiality in the interview was given to all participants. In order to ensure the confidential state of the interview, the recordings were destroyed by 06/01/2017 and all no names will be listed in the research findings; names will be changed to numbers. No identifying information was given regarding the participant's place of employment or other identifiable factors.

Potential risk for the participants of this survey were minimal. Risks included possible disclosure of information relating to their work that might negatively frame the agency in which they are employed. Participants might have feared that information given in the research interview may get back to their supervisors. For this reason, participants may have refused to answer any question that makes them uncomfortable or could possibly lead to identifying information about their interview being recorded in the interview session. Additionally the researcher worked to provide strict confidentiality of research participants through ensuring privacy of the interview room and strict care when de-identifying information about the participant.

Participants of this survey were given and informed consent outlining the background information for the study, its procedures, and its risks and benefits. The participants were notified of the confidential of the survey, and that their participation in the survey is voluntary.
In order to participate in the study the participants had to go over the informed consent forms with researcher and sign off on forms. Participants were encouraged to ask questions or bring concerns to the researcher at that time. Participants were informed that at any time during the interview they could choose to stop the interview, or choose to not answer a question, with no negative consequences from the researcher.

Confidentiality was discussed with participants. All recordings were be kept on a password protected electronic device and stored in a locked and secured area. All identifying information of participants was omitted from the research findings. For the purpose of coding and reliability check, the transcripts of the interviews were not be shared anyone. Because of lack of reliability check, the results of this research may not be generalizable.

**Instrument**

The instrument used for this research consisted of the semi-structured interview questions that are provided in Appendix A. The interview consisted of demographic questions and open-ended questions to solicit professional experience and expertise on working with children impacted by domestic violence exposure. Demographic questions included some of the following: ethnicity of participant, religious background, and agency setting the participant is employed in, years of practice experience, number of clients each year the participant works with whom are exposed to domestic violence. Open ended questions centered on the following topics: impacts on mental health/ behavior of children exposed to domestic violence, best methods of treatment for children exposed to domestic violence, and best practices on working with the family impacted by domestic violence. An attempt to reduce bias in the interview questions was made through the use of committee members’ influence in the interview schedule. The use of committee members in the review of the interview schedule included:
1. Provision of feedback and input of research questions,
2. Collaboration on revisions and refinement of the interview schedule, in order to help reduce bias of questions included in the interview schedule.

Data Collection

In order to generate interview participants (and data from the interviews to be analyzed) the following took place:

1. Each committee member on this project was asked to supply 2-3 contacts of possible participants for this study.
2. Researcher then contacted participants (via email) to inquire if participant would be interested in partaking in this research and agreeable to an interview.
3. If participant was not agreeable to an interview, researcher then enquired if they might have another participant to suggest.
4. If another candidate is suggested, researcher then repeated steps 2-4) until an agreeable candidate is found.
5. Once an agreeable candidate for research participation was located, an interview date was scheduled and the participant was emailed a copy of the interview schedule and informed consent letter to review, sign and complete prior to the formal interview process. The participant was notified that estimated length of interview would be 60-75 mins and would take place in a confidential place of their choice (participant’s office, university meeting space, or public library meeting space).
6. On the scheduled date of interview, the researcher conducted the semi-structured interview with participant and recorded the interview for later transcription. The researcher also collected the interview schedule that was provided to participant (prior to
date of interview) for review of written responses to interview questions at a later date.

7. At the conclusion of interview, the researcher asked the participant if they knew of other professionals working with children exposed to domestic violence, who they might refer to this research project (snowballing technique). If candidates were recommended, researcher then began this process at step 2.

The interviews were administered in a private setting of the participant’s choice (examples of this consisted of the participant's office, a university meeting space, or a public library meeting space). In the case of distance issues, the interview took place via telephone or skype, in a private setting of the researcher and interview’s discretion. The interviews were estimated to take between 60-75 minutes of the participants time, with no further follow up needed from the participant. The interviews were recorded for later transcription and analyses. All participants were assigned a number to identify their responses and data, and names were not be included to ensure confidentiality. All recordings were be destroyed by 06/01/2017 to ensure confidentiality.

Data Analysis

At the completion of the interviews, each individual interview data was transcribed from the recorded session. An audio slowing program called Express Scribe was used in order to assist in the transcription of the data. The transcription was typed out for analyses and coding.

A grounded theory approach was used to analyze the data from the semi-structured interviews, searching for emergent themes. The first step in analysis was the use of open coding to synthesize the data. This will be done through a line by line analysis in which the coder sought to synthesize the sentences to answer the questions: “what is being referenced here” into one word or phrases (Glaser & Strauss, 1967). Then axial coding was used to extrapolate common
themes that recur from the open coding, as well as sub-themes. Lastly, selective coding was used to determine the story that is being told from the data, and how each theme relates to one another. Due to the time constraints of this research project, an intra-reliability check was not incorporated into the analysis.
Findings

Sample

The interview timeframe for this research project ranged from February 20th 2017 to
April 10th 2017. The sample consisted of professionals that were drawn from referrals from
committee members, this included personal referrals of professionals known to work in the focus
area of this research, as well as connections to agencies where Domestic Violence work is
happening and the focal point. A snowballing technique from recruited participants was also
implemented to attempt to recruit more participants. Additionally, a public posting on
Minneapolis SWAPS- Twin Cities social media website (Social Work Allied for Problems
Solving) recruiting professionals who work with children exposed to Domestic Violence.

Recruiting participants. Referrals for participants who would be eligible to participate
in this research project was the first step in recruiting a sample. From the four committee
members (researcher included) 20 different practitioners were identified as potential participants
who would qualify for this research study, or who would know other qualified practitioners who
would be willing to participate. Out of the initial 20 referral emails sent out, one qualified
candidate was recruited to participate in the study. The remaining 19 candidates either did not
respond to the invitation to participate or had varying response for not participating.

A technique implemented in the recruitment for further research participants was that of
snowballing technique. Two of the four participants did give referrals to other professionals.
Out of the referral emails generated from participants through snowballing technique, three
emails were sent to specific professionals.

Social media was also a source for recruitment. A post was made to a local Social
Worker Resource page, requesting qualified candidates for the study. Response rate from the
social media post included: responses from seven professionals (four professionals who personally thought they would like to participate, and three professionals with agency recommendations to connect with). Of the four professional responses to the social media post, three of these professionals did qualify and choose to participate in this research project.

**Potential participant responses.** The most common responses from practitioners who were invited to participate via email was no return email or response. Due to the time limit of this research study, in the invitation to participate email, there was set forth as a deadline for response to the researcher if the referred practitioner desired to participate. Due to lack of response, these practitioners were then considered as “declining the invitation participate”. Another reason for practitioners decline to participate in the research study was time constraints; specifically three practitioners reported that they did not have any open time during the day for participation in this research study due to heavy caseloads. Lastly, a common response reason for professional’s decline to participate in the research was due to ineligibility. Due to a qualifying factor of this research project being a professional who’s percentage of caseload of children exposed to Domestic Violence being a minimum of 50% or more (initially this rate was at 75% but due to limited responses the researcher had to drop the rate in order to widen the recruitment pool), some practitioners stated they were ineligible for the research study, as not meeting that percentage.

**Sample demographics.** From the professionals who participated (N=4), the sample included 1 male, and 3 female professionals. Demographics of these professionals included: 3 self-identifying as Caucasian, 1 as Hispanic/ Latino. The sample consisted of 1 participant identifying in the age range category of 21-29, 2 in the range category of 30-39, and one in the category of over 60. Participant religious backgrounds included participants identifying from 1
Christian; covenant background, 1 Atheist background, 1 Christian; unspecified background, and 1 Agnostic background. 1 Participant was employed with an agency that was religiously affiliated, specifically Christian affiliation. Professionals interviewed had varying credentials, but all were licensed, including 3 LICSWs and 1 LGSW.

Professional’s place of practice varied from 1 Elementary School practitioner, 1 Child Protective Services practitioner, and 3 Community Mental Health Clinic practitioners (1 participant worked at 2 agencies thus the reason for 5 responses). Practice experience ranged from 1 year to 7 years, with the average being (1, 3, 5, and 7) 4 years of experience in the profession. Caseloads of interview participants ranged from 9-23 clients (9, 18, 20 and 23) averaging 17.5 clients. Percentage of caseload impacted by domestic violence were, 65%, 100%, 70% and 62%.

Table 1

<table>
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<tr>
<th>Participant</th>
<th>Gender</th>
<th>Race</th>
<th>Licensure</th>
<th>Employer</th>
<th>Length</th>
<th>Caseload</th>
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<td>Caucasian</td>
<td>LICSW</td>
<td>MH Clinic</td>
<td>3 years</td>
<td>65% DV</td>
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<td>Hispanic</td>
<td>LICSW</td>
<td>MH Clinic</td>
<td>5 years</td>
<td>100% DV</td>
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<td>70% DV</td>
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<td>LICSW</td>
<td>MH Clinic</td>
<td>7 years</td>
<td>62% DV</td>
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</tbody>
</table>

Themes

Recorded interviews were transcribed into written transcripts for researcher analysis. The researcher reviewed transcripts line for line and coded them. After coding, major themes were
pulled from the data using axial coding. Themes were qualified under the stipulation that 50% (two out of the four) of the participants identified the same idea in their interview. Quotes from the data (interviews) used to highlight themes in the “Findings” section of this paper will be identified in italicized font and indented/ separated from the rest of the prose.

Three main themes presented themselves from the research interviews with professionals. The three themes consisted of 1. Symptoms/impacts of domestic violence exposure; 2. Age appropriate treatment recommendations for domestic violence exposure 3. Professionals getting the “big picture”. Each theme is discussed below with identified sub-themes discussed independently.

**Symptoms/impacts of domestic violence exposure.** From the interview questions “How does domestic violence exposure present itself in a child's daily interactions (I.e. behaviors exhibited at school, home, community)?; What are the impacts of domestic violence on children's mental health? Short term? Long term?; Are there are typical types of diagnoses that present themselves in regards to children who have been exposed to domestic violence?” came the themes of symptoms and impacts of domestic violence exposure on children. All of the professionals who participated in this research described the impacts of domestic violence exposure in detail in the interviews.

Common sub-theme under this section included the emphasis on symptomatology being variable, and different for each child exposed. In regards to variations, it was also a noted by participants that variations in the environment impacted symptomatology, and how they play a large role in impacting symptomatology expression. The majority of the symptoms can fit into one of two sub-categories under symptomatology; internalizing or externalizing symptoms which will be further discussed below. The final sub-theme that came out of this section was the impacts of domestic violence exposure on young children developmentally, referencing social, emotional,
cognitive and neurological development and how it can be adversely impacted.

**Variation in symptomatology.** All four interview participants made reference to the sub-theme of individual variation of symptomatology based on the circumstances of the child. Each practitioner described certain behaviors or symptoms that a child might display, but also noted that it is variable. Caution was given by participant as to not try to put all the symptoms of domestic violence exposure into one box or category, as they change from child to child and can be expressed or manifested in many different ways. A quote from participant #4 that highlighted the variation of symptomatology is as follows:

*Yea so it's such a variety. It's so unique to each child. I really think that based on age, gender, protective factors, external supports that the children have, as well as coping skills that they have learned from their parents previous to their witnessing or while they were witnessing domestic violence. It can look a lot of ways.* (Participant #4)

This quote highlights the uniqueness of symptomatology express from the practitioner's’ point of view, as well as variables within the environment that the practitioner believes impacts how a child will respond.

**Internalizing symptoms.** Common in the participant interview was the sub-theme of internalized symptom/behavior expression, under the theme of symptoms associated with domestic violence exposure. All four participants referenced internalizing symptoms that result from domestic violence exposure. This is a grouping of symptoms based on the expressed symptoms or behaviors being primarily introspective, affecting the individual internally versus externally. Examples of these from the results include depression, anxiety, post-traumatic stress disorder, somatic symptoms, enuresis, sleep disturbances, self-blame, low self-esteem, social isolation or “shutting down”, and vulnerability to bullying.

**Externalizing symptoms.** The second area of common sub-themes under the umbrella of
symptoms was that of externalizing symptoms. Externalizing symptoms or behaviors consist of expression of domestic violence exposure through external actions or behaviors that impact the environment. From the participants this was described as “big behaviors” such as tantrums or “acting out”, violent outburst, taking on the role of a perpetrator (displaying learned behaviors from the abuser in their family), testing limits within authoritative relationships, and destruction of property, hyperactivity, and inattentiveness. A quote that highlights the behaviors under this subcategory:

...I think what we see is concerning behaviors like hitting, screaming, yelling “no”. Some other examples that have happened is acting out a violent behavior such as climbing on top of someone, and like fighting them, like you probably have seen in a domestic. A child that we actual have right now, that is a kindergartener, he has done things like run out of the classroom; he’s loud; he doesn’t really know social rules. He’ll hit adults and other children. I think those are, it’s really behavioral based, all things that are out of the norm. (Participant #3)

The above quote highlights some of the typical externalizing symptoms/behaviors that are present in children exposed to domestic violence, and provides a case example of a child the professional is working with who presents these issues.

**Developmental Impacts.** Another subcategory for the theme of symptoms is that of developmental impacts. From all four participants came a theme of developmental impacts on children exposed to domestic violence. Included under this category is impacts on social, emotional, cognitive and brain development (neurological). A quote from one of the interviews highlights the impacts of domestic violence exposure on early childhood development:

*For 2-6 yr olds, it can on average, children who witness DV are behind 6 months with typical developmental milestones being met, but it can vary significantly. So general social emotional development, can be delayed, and cognitive development can be delayed.* (Participant #4)

Impacts can be varied depending on the child and the factors surround the witnessing of the
abuse and the supportive factors surrounding the family, but clearly from the above statement, it is clear that there are adverse repercussions for children who are exposed to domestic violence.

**Variations surrounding the family of which impact symptomatology.** The last sub-theme that came under the umbrella of symptoms was that of variations surrounding the family of which impact symptomatology. From all four professionals came the theme of how support systems (or lack thereof), environmental factors, cultural considerations, and systems relationships could impact the development of symptomatology. Examples of this includes things that happen as ripple effects of a domestic violence event transpiring; children being removed and placed into foster care system; police involvement, mother/ victim of violence being sustaining life threatening injuries; or the family having to move to a new place or reside within a domestic violence shelter; these are just a few examples. A quote that highlights the importance of factoring in environmental effects on symptomatology is as follows:

> For me I feel any age you experience trauma, I don’t know if the age necessarily matters, what I would say is, the impact on mental health due to domestic violence is increased if there are no supports in place for the family whether the child is three months old or two years old or 17. The child has their own experience to that event, and now it’s up to the family system, to the community, to the professionals to help that child process it. So for me, regardless of age, that is the biggest effect of how it will minimize the effect on MH is what outlets can we provide that child. That is what I would say. I think the most important thing is intervention. (Participant #2)

A second quote that highlights the importance of environmental impacts that affect the child is:

> And then what has transpired from that…. I have a few students, who you know they are in the cycle of- there’s domestic abuse at home, then they will leave with- in the case I am thinking of- with mom, and they go to a shelter for a period of time, and then they leave the shelter and then dad comes back, and then they go back into the shelter. And I think this has transpired 4 or 5 different times. So obviously, not only are they experiencing the domestic violence component of things, but then also the disorder that comes with different living scenarios, and living within a community space within the domestic violence shelter and what they experience and see there. And then, you know, just a lot of inconsistency... So it just completely depends too, on -are they staying at home, is the, ya know, perpetrator staying with them?; -or is it this they come they go, they come they
go?; -are they physically leaving?. I think it all depends on that... The other part of it is whether or not there’s ever been, like I am thinking of one student who there was some domestic violence in the home, mom was pretty severely injured to the point where she was in the hospital for a period of time. And then mom’s boyfriend was tried. And so I think they felt like there was some sort of supported justice that was taking place, while at the same time they were super scared about if he doesn’t get sentenced to be locked up, what’s going to happen? (Participant #1)

Each professional, whether it was the Child Protective worker highlighting the impacts of foster care and multiple foster placements on the child; or the Community Mental Health Worker who contracts with Support Housing emphasizing the impacts of lack of community support for the families; or the School Social Worker emphasizing the factors of inconsistency in the environment and how multiple changes can adversely impact coping abilities; or the Community Mental Health Worker who works at a domestic abuse center, pointing out the importance of external supports and protective factors that surround the child; all four professional stressed the importance of the environmental factors and changes that the child experiences as a result of domestic violence exposure and how it impacts coping abilities, attachment formations, and adverse mental health symptom expression.

Age appropriate treatment recommendations for domestic violence exposure. From the interview schedule, the question “In your experience, what treatment methods have been the most effective in working specifically with children aged 2-6 who have been exposed to domestic violence?” generated the theme of Age appropriate treatment recommendations for domestic violence exposure”. Under this theme, there were a few recommended treatment methods common to all participant responses. Those included therapy models for individual treatment such as Child-Centered Play Therapy for children aged 2-6, Child-Parent Psychotherapy for the children aged 2-4 (especially for the younger children), and Trauma Focused Cognitive Behavioral Therapy for children 5-6. In addition to the individual therapy models, a common theme from the data came a need for
wrap around services or family therapy. Lastly, a subtheme from this category came the basic principle of treatment being consistency.

**Child-Centered Play Therapy.** From all four interview participants came the theme of recommended use of play therapy as a best practice treatment model for working with children exposed to domestic violence aged 2-6. Child-Centered Play Therapy is defined by one National Institute as:

>“Child-Centered Play Therapy (CCPT) …. [Is a therapy that creates] a non-judgmental, emotionally supportive therapeutic atmosphere, but with clear boundaries that provide the child with psychological safety to permit the learning of emotional and behavioral self-regulation. Research has validated that this is a powerful method for decreasing a wide range of child problems, for overcoming traumatic experiences, for developing expressive freedom and creativity, and for building self-esteem and more mature, prosocial behaviors.”

(National Institute of Relationship Enhancement and Center for Couples, Families and Children, 2017)

One participant narrowed down her recommendation of play therapy being specifically for the 4-6 year olds. Another participant had the following quote when talking about the importance of play therapy use when working with younger children:

>And depending at the age, getting outside the 2-6 range, about 11 years old you can begin to do more talk therapy. Can’t really do it with a 3 year old because they are just not talking yet and developmentally they just don’t have that capacity. The language is play, kids language is play through re-enactment, the goal is them processing the energy that is just going through their body. (Participant #2)

From three out of the four participants came the theme that children express themselves through play, and the language of the young child is play; thus it makes sense that the treatment modality focus on play and expression of trauma through the child’s play.

**Child-Parent Psychotherapy.** Two of the four participants specifically recommended Child-Parent Psychotherapy (CPP) as a best practice treatment method for children exposed to domestic violence. A third participant spoke about the importance of attachment and healthy
attachment, and the ruptures that can result as an effect of domestic violence exposure, but did
not specifically mention that CPP was a treatment model that she used in her practice. In parent
child psychotherapy, both the parent and the child are in therapy together, working to improve
the attachment and the parent/child relationship. CPP is defined by The California Evidence-
Based Clearinghouse as:

“CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen
with his or her primary caregiver, and the dyad is the unit of treatment. CPP examines
how the trauma and the caregivers’ relational history affect the caregiver-child
relationship and the child’s developmental trajectory. A central goal is to support and
strengthen the caregiver-child relationship as a vehicle for restoring and protecting the
child’s mental health. Treatment also focuses on contextual factors that may affect the
caregiver-child relationship (e.g., culture and socioeconomic and immigration related
stressors). Targets of the intervention include caregivers’ and children’s maladaptive
representations of themselves and each other and interactions and behaviors that interfere
with the child’s mental health. Over the course of treatment, caregiver and child are
guided to create a joint narrative of the psychological traumatic event and identify and
address traumatic triggers that generate dysregulated behaviors and affect.”
(The California Evidence-Based Clearinghouse for Child Welfare, 2017)

A quote from one of the interviews, speaking to the age group that her agency specifically
focuses CPP treatment with, is as follows:

And we really have continued to go down the ladder and work with kids of all ages
now... For kids infants to 3 years old or 4 years old really benefit from dyadic work with
their caregiver. Because it is within that relationship that they are able to develop their
social emotional skills, cognitive skills all of those things happen within the relationship.
So we need to be intervening within that relationship, which happens through child
parent psychotherapy. (Participant #4)

Getting family involved in the treatment process was a theme that came through in all for
participant interviews and is utilized in this method of treatment. This theme of family
involvement will be further discussed in the theme sub-theme Therapeutic services for the
family.
**Trauma Focused Cognitive Behavioral Therapy.** Trauma Focused Cognitive Behavioral Therapy (TF-CBT) was a sub-theme under the treatment umbrella that two out of the four professionals directly referenced as a treatment method that they utilized with older children in the range of 2-6. A third professional referenced skills that are utilized under the treatment implementation of TF-CBT, but did not specifically reference the model as a treatment modality. TF-CBT is defined as a treatment:

“which is an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic events. The treatment—based on learning and cognitive theories—addresses distorted beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.” (Child Welfare Information Gateway, 2012)

TF-CBT theme presented while not present among all four interviews, was substantiated as a theme by the direct reference by two participants as a preferred treatment method, and by indirect referencing from a third participant. Additionally as noted in the definition, the focus of the treatment on both the child and the adult caretakers was also a common theme amongst all participants and discussed in the next section.

**Therapeutic services for the family.** Therapeutic services for the whole family was another sub-theme under this theme. All four professionals referenced this sub-theme within their interview, and the importance of wrap around services which support the entire family. One quote that highlights this well is a participant talking about a successful client and what that looked like:

*The entire family was involved in services here at some point, which I think is really beneficial, and I don’t think I mentioned that. I think having a place where there is holistic services where mom, dad, kids whoever it may be involved in the family has a*
This quote highlights the importance of treatment for the whole family, in order to heal and restore healthy relationships. According to the interviews this therapeutic family work can occur through child-parent dyadic work (CPP, TF-CBT), family therapy- which would include all family members impacted by the abuse, all family members getting individual therapy- focusing on the abuser getting help with abusive behaviors in order to stop the cycle of violence, and through psycho-education from the child’s therapist to the adult caregivers.

**Consistency as a basic principle.** In response to the question “Can you provide from your practice experience an example of a case where a method or intervention was used that was successful?” a theme was identified with three out of the four participants, that of providing consistency. One participant stated that for the most severe cases of children exposed to domestic violence, day treatment programming was the best recommendation for that child, to provide a consistent daily routine. Two other participants emphasized the importance of consistency being provided by the intervening therapist and attempting to make the environment consistent for the child as well. A highlight from one interview was in this sub-theme was:

*I think it's hard because there are definitely cases where things were helpful, but I wouldn’t say that it was defined by method or intervention.... So it's just really complicated, but honestly going back to the question, the method, the intervention that was most successful was consistency. Consistently being a part of their life. And basically saying “I am not going anywhere; everyone else has left you. Your family has come and gone; your dad has come and gone; your housing has come and gone. There is really nothing consistent in your life. But we are going to do the best we can to be consistent for you.” So I’d say that is probably the most successful intervention. (Participant #1)*

In the above example the participants stressed the importance of consistency in the provider relationship when working with children and families impacted by domestic violence, as being as
important as any treatment tool that is used.

**Professionals getting the “big picture”**. An important theme that came up throughout interview questions in this research study was that of the need for professionals to look at the “big picture”, seeing the person in the environment, generational cycles, culture, and digging deep in the assessment to gain insight into the family life and root causes of symptomatology. Variations in the environment and how they impact the child who is exposed to domestic violence were discuss in the previous theme, but it should be noted here again that this was a major theme that came up in all of the participant interviews being the importance of looking at the “person in the environment”. Different things happening in a child’s life will impact symptomatology, treatment effectiveness, and outcomes. Under this theme also came the impacts of professionals not seeing the “big picture”, resulting in misdiagnosis. Additionally under this theme umbrella came the theme of domestic violence being common and impacting people across the board. Lastly, a subtheme from this category was that of the need for professional collaboration in order to better treat and make early interventions.

**Misdiagnosis**. A theme that was present in every interview was that of misdiagnosis of mental health issues by providers servicing children who are witness to domestic violence. From all interview participants, it was noted how the symptoms associated with trauma from domestic violence exposure could mirror symptoms of disorders such as Conduct Disorder, Oppositional Defiant Disorder, AD/HD, and even labeled as “low functioning”. An emphasis from all participants was placed on the provider conducting assessments responsibility to ensure that a thorough assessment is completed of which factors in the person in the environment analysis. Participant 4 stated: “And really understand that a thorough diagnostic assessment means really understanding family history and relational and relationship history. So that we can make sure
that we are using a systems lens and a person centered lens when it comes to what the child needs most.” highlighting the importance of a in-depth assessment to rule out misdiagnosis.

Additionally, Participant 1 stated the following value she holds as a professional and reminds teachers of when working in School Social Work and ruling out the diagnoses of Conduct Disorder or Oppositional Defiant Disorder:

*Yea, instead of just seeing it for face value [the symptoms], recognizing that there is purpose and reason behind the behavior. We talk about functions of behavior a lot with teachers, and saying “it's not really about whatever the behavior is, let's figure out why, why is that behavior working” because they are doing it repetitively so obviously there is some sort of functionality of the behavior. I come from the belief that behaviors are functional, they are not necessarily just to be naughty or mean, and so recognizing that.* (Participant #1)

A second quote from one of the interviews came regarding the importance of weeding out incorrect diagnoses due to adverse effects of medication in the treatment of disorders that mirror trauma from domestic violence exposure:

*To really understand, is that PTSD and ADHD really mimic each other. The same sort of behaviors fall into each diagnosis. And often times schools focus on behavior, behavior, behavior, and its “he needs to be assessed for ADHD” and mom comes in and says “he has ADHD”. But we are not asking enough questions as professionals of “Hey what's going on at home”; “How’s his environment?”; “What’s happening there?”. And often times when we do, we realize that there is a lot going on, a lot of domestic violence going on. And that changes things. ADHD you give a kid a stimulate to slow down. We are not going to give a kid who has PTSD a stimulant that is the opposite of what we want.* (Participant #2)

A strong theme was that of recommendation for thorough assessment coming from this research project. As stated by the professionals who participated in the interview, it is necessary in order to reduce misdiagnosis and avoid medicating a child for a disorder that they child does not have.

*Domestic violence is common and impacts everyone.* Three of the four respondents produced a sub-theme of domestic violence being common and impacting all socioeconomic categories. Emphasis was placed on the fact that domestic violence impacts all people, rich,
poor, minority and majority, in all areas of the world. In light of this theme, it was mentioned that more education needs to be given to professionals making diagnosis, community resources (governmental funding) allocated to domestic violence education and early intervention screening, and psycho-education to raise awareness of the impacts of domestic violence on children.

The need for systems to work together to support the family. A final the sub-theme that presented itself throughout the interviews with professionals was the need for systems to work together to support the family and create health, healing and change with the entire family until. All the interviews had the theme interwoven throughout their responses of the importance of systems support of the family, and providers working together to support the family. Under this umbrella were recommendations of dyadic work, family therapy, community supports, systems communicating and working together to make impactful changes, and importance of expanding systems services to better serve and intervene earlier. A quote that represents the importance of systems work and expansion of services is as follows:

The good thing is there has been a lot more, I think, awareness, and hopefully more funding will be allocated to early childhood interventions. And specifically early childhood mental health interventions. So more developmental social emotional screenings for kids everywhere... So we need to ensure that there are appropriate development screening of every child, and offering that within a variety of community settings. (Participant #4)

Important in this section is also the recognition of the need to have support systems (governmental or community based) in place for families who have witnessed and are fleeing domestic violence situations; supportive housing, legal services, county financial assistance, domestic violence shelters, and wraparound treatment services for both the victims and the abuser to get needed treatment to heal and help end the cycle of domestic violence. An example
quote highlighting the importance of this is participant 1 highlighting a successful client scenario:

*I think it's important to note, they have a ton of county of support. So their ability to just flee the county; it's not a viable option for them, because they may not have the same county supports and county case manager and all that good stuff from one county to the next. They have to stay within the context of [the existing] county if they want to continue to receive the level of support that they have been receiving. And so, that's tricky too. Where a lot of people say “why don't they just move” and I would say it's not that easy. And so I would say they are incredible healthy today. I was able to get them stable housing...* (Participant #1)
Discussion

Sample

In completing this project, a major barrier to get a sufficient sample was the stipulation on practitioner's caseload “working at least 75% (carrying a caseload of 75% or more) of the time with children who have experienced trauma aged 2-6”. Outside of agencies that focus specifically on domestic violence, this was a difficult stipulation to meet. The researcher then revised the stipulation to the practitioner needing to meet a caseload of 50%, and in doing so, this allowed 3 more participants to join in the research study, who otherwise would not have meet criteria. In this way, the sample selected for this study may not represent everyday practitioners, as the ones for this study focused or worked more heavily with children exposed to domestic violence, than many practitioners in an everyday community mental health setting might see.

All the professionals that participated in this study had attainment of licensure in their field. This fact may speak to the effect that all participants in this study had a high level of commitment to their profession. This may help to strengthen the results of this study, as the professional whom participated in this study may be considered “experts” in the field, due to their level of education, licensure and training in working with children exposed to domestic violence.

One additional consideration of the sample is that of the four participants in the researcher, three were employed with Community Mental Health Clinics, and one with Child Protective Services. In the case of the Child Protective Services worker, her role in working with children impacted by domestic violence, is very different than that of the Mental Health Practitioner. This specific participant did not provide direct services to children impacted by domestic violence, but instead provides services to the whole family and makes referrals out for
children who need to seek mental health attention. In this way, the participant sees the impacts of mental health services that are provided to the child, but the practitioner is not the one providing the direct services. In this light, it might be considered that her professional knowledge is that of second hand experience, observation, instead of first had direct services.

**Themes**

Much of the findings from this research project matched the existing research on witnessing domestic violence exposure. A few themes emerged that detailed more in depth experiences of the professionals in their work with domestic violence exposure and best practice treatment strategies. Below is a discussion of the themes and commonalities and variations compared to current existing research.

**Symptoms of domestic violence exposure.** The theme of “symptoms of domestic violence exposure” and the sub-themes that were generated in this category matched well with what the research has shown as far as symptom expression. Yoo & Huang’s (2013) study found children exposed to domestic violence correlated with behavioral issues, children’s delinquent behavior problems, children’s anxious-depressed behavior problems, and children’s withdrawn behavior problems. All of these same symptoms were noted as examples of symptomatology from the data in this current study. In addition to the above study, de la Vega et al.’s study on children exposed to domestic violence (2011) produced results similar to that in this research study. Children exposed to domestic violence had a correlation between an increased likelihood of internalizing psychopathology, increased risk of suffering from major depression, impairment in emotional development as well as psychological development. (de la Vega et al., 2011)

Something that was different in this study, and not noted in the research, was the importance of environmental factors and their impact on symptomatology expression. Each
professional interviewed in this study stressed the importance of recognizing the impacts of the environment (protective factors, resiliency, support systems, etc) on how domestic violence exposure would then be expressed by the child. Also stressed in the data was a theme of the ripple effects of domestic violence exposure can adversely impact childhood trauma as well, resulting in complex trauma, or reduced supports for the family to utilize for coping (examples included CPS removal of a child, multiple foster home placements, homelessness or housing instability, legal system involvement, etc.). The author of this project speculates that this theme was not present in the literature due to the complexity of attempting to document this information. The factors that could impact symptomatology and expression of trauma are vast, and trying to create an experiment, have a control group, or document differences would be complex.

**Age appropriate treatment recommendations for domestic violence exposure.** From the existing research, and again highlighted her in this study there is mention from the practitioners/ participants emphasizing the importance helping the family cope. In an existing research study of with a focus group of domestic violence practitioners, a theme from the group came the need to placing less emphasis on clerical works and more focus on the family and helping them cope (Clarke & Wydall, 2015). This research resonates with the sub-theme under treatment recommendation for family work to be done to support the entire family and help them cope, heal and return to healthy functioning after domestic violence incidents have occurred.

In regards to specific treatment methods that are utilized for best practice, 3 main treatment methods were mentioned in this research study and all three methods were also mentioned in the existing research. This study, particularly, narrowed the treatment methods to three main treatments that are most effective with children aged six and under. From the
literature, a study found Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief (TG-CBT); Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP); Attachment, Self-Regulation, and Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth; Child-Parent Psychotherapy (CPP); and Parent-Child Interaction Therapy (PCIT) as effective treatments for dealing trauma from domestic violence exposure (de Arellano, et al., 2008). This study, focusing on children 2-6 found the most effective methods were TF-CBT, Child-Parent Psychotherapy, and Child-Centered Play Therapy; which is mirrored in the research, but narrowed down in comparison to other recommended methods. Additionally, it should be noted that this study suggests medication for children exposed to domestic violence aged 2-6 should be deterred from, and this is also supported in the literature; as noted in the Lieberman study, the use of psychopharmacological treatment for children under age 5 is not currently recommended. (Lieberman et al., 2011)

Difference from this research in comparison to that of the literature review included, the emphasis on consistency as an important theme and basic treatment principle. This study had a sub-theme of the importance of consistency as a treatment intervention. The author of this project speculates that this might not have been emphasized in the literature because consistency as a treatment method is too common of an intervention, and it may be assumed that the therapist providing services would base his practice in consistency. The theme and repeated emphasis by the participants in this project, lends itself to point out to practitioners the importance of this therapeutic tool in providing services to children exposed to domestic violence

**Professionals getting the “big picture”**. Another theme that came through from this study was that of “professionals getting the “big picture!””. This theme was supported in the
literature as well, as a few studies spoke to the same sub-theme of this research project of “systems needing to work together to support the family” and studies highlighting this fact under the emphasis on the lack of services or screenings for domestic violence taking place in the home (i.e. screenings in schools, clinics, emergency rooms, common entry points) and recommendations to improve this (McMahon & Armstrong (2012); Yoo & Huang (2013); Carpenter & Stacks (2009)). Carpenter & Stack’s work stating that “...Less than half (43.1%) of child welfare agencies report that they assess 100% of all of the families who are referred to them and that most referrals take place at investigation” and a study by McMahon & Armstrong (2012) showing lack of screenings for domestic violence being implemented by health and social work professionals during pregnancy and the studies recommendation for improvement, reiterate the themes under “Professionals getting the “big picture!”” in this research study.

**Misdiagnosis.** Lastly, a theme that came through, which was not present in the literature was that of misdiagnosis. A study done by Meltzer et al. (2009) found that witnessing domestic violence was associated with having conduct disorder, however, from the research participants in this study, conduct disorder was mentioned as potential misdiagnosis (instead of recognizing the trauma the child(ren) suffer from domestic violence exposure). Another study done by Yoo & Huang (2013) found that children exposed to domestic violence at age one had behavioral issues presenting at age five including “delinquent behavior problems”; this study again focuses on the behavior of what the child is exhibiting and not the trauma that the child has witnessed.

**Researcher Reaction.** In regards to the findings that were produced from this research, much of what came out in the themes mirrored what was found in the current research on implications of domestic violence exposure on children’s mental health and treatment methods. The researcher’s reaction to this research was, one being specifically, a reaction to one of the
interviews with a participant and her statement regarding best treatment method being that of the practitioner providing consistency to both the child and the family. This basic principle of human service work was driven home by this participant, as well as was a re-occurring theme amongst other participants in this study, as an important and defining factor in producing effective results and successful interventions.

It was refreshing to be reminded of the basic importance of the entry level skill in human services (and in a therapeutic relationship) of consistency. The skill is not only important in setting boundaries and rules in the services setting, but in this research there was an emphasis placed on the consistency as it relates to human connectedness, attachment, and creating new relational patterns for clients. In implementing this one small factor for a client/family it was highlighted by these professionals how it can impact and successfully influence treatment of children (and really entire families) who have suffered trauma from domestic violence exposure.

**Limitations/ Recommendations for Future Research**

One limitation of this study is the generalization to other practitioners, or representation of the wider public. The sample size is a small sample, therefore making generalization to other practitioners less relevant. Additionally, because all of the practitioners were practitioners from the Minnesota, generalization to other regions of the United States, or other regions of the world, may not reliable and larger studies might incorporating a larger sample and covering more regions might produce differing results.

The small samples size was due to difficulties had in recruiting qualifying professionals to participant for multiple reasons, including recruiting available professionals that met qualifying criteria for the study under the category of “percentage of caseload exposed to domestic violence”; finding professionals who were willing (and had time) to participate in the
research; and finding professionals who did not have legal constraints (their employers’ IRB prohibiting them). Finding practitioners who worked with children exposed to domestic violence with a caseload of 50% or more was a challenge; many practitioners carry mixed caseloads, and did not meet this criteria. Another challenge was that of professionals being overburdened in their caseloads and unwilling to participate in the study due to time constraints placed on them by their agencies. Yet another issue was that of agencies that provide day treatment services to children aged 2-6, and those agencies having their own IRB, thus restricting professionals from participating in this research project due to non-IRB approval with their specific agency. Of the participants who responded to the invitation to participate, three stated that they did not have time in their workday to allow for research participation due to heavy constraints on caseload; declining to participate in the research due to time constraints equaled 11% of the contacted potential participants. One might also consider that of the 54% of non-respondents to the invite to participate in this research project, time may have been a factor in their lack of response. Additionally, the short window of time that the researcher had for data collection from February 20th to April 10th (7 weeks), placed a restriction on how many practitioners could be contacted and snowballing technique effectiveness with later interviewed participants because of cut off for data analysis for anyone that might be referred from that snowballing effect. Some ideas to help increase participant recruitment in future research could include: face to face introduction of the study to agency leaders in order to gain support in the research project, offering online anonymous survey to collect a larger sample and reduce the amount of time the participating practitioner would have to spend; utilization of focus groups; or providing an incentive such as a gift card for participants.
**Recommendations.** Future research recommendations include doing research on agencies, allotting more time for recruitment of sample, and direct calling to participant referrals (in addition to email). In doing more research on agencies that might professionals might be recruited from to participate in this research project, this would serve to avoid the dilemma of attempting to recruit participants from agencies who have internal IRBs (which then restricts those professionals from participating in outside research without their agencies IRB approval). If that specific agency is deemed desirable to have practitioners from the agency participate in the research project, then this would allow the researcher preparation time to submit IRB approval to those agencies ahead of time, or brainstorm additional agencies that might not require IRB approval. In addition, a face to face introduction to the agency stakeholders/ leaders would also help to gain agency support and employee buy in for participation. Allowing more time for recruitment of the sample would be helpful to future research in hopes of generating a larger sample size. Due to time constraints of this research project, the allotted seven weeks of time to recruit the sample produced a low sample size. Lastly, a recommendation for furthering the sample turn out in the future would be to introduce the “invitation to participate” with a call to referred participant. Due to referrals coming from committee members or participants in the research, often times only an email was provided as a contact method for the researcher to use. If no response was received by the researcher, then the researcher had no choice but to consider that participant ineligible/ unwilling to participate, but with no clarifying information as to why. Being able to introduce the research to the potential subject by conversation may have been helpful in getting more information on why there was a 54% non-responsive to the invitation to participate.
Implications for Social Work

Implications for social work include the emphasis on continued need for funding of services to community mental health, specifically for programming focused towards early childhood treatment and interventions (across the board screenings). This was highlighted in the literature as well as in the data from this research, the importance of continuing advocacy for funding to increase awareness of impacts on domestic violence (psycho-education), increasing funding for treatment (creating holistic treatment centers with the focus of treatment for the entire family), and developing and implementing community screenings to better increase chances of early detection and intervention. Additionally, it would be advisable to increase the training supports for clinicians who will be working with families exposed to domestic violence, and increase the number of agencies that provide wrap around services for the families impacting by domestic violence (as this is such a common societal issue).

A second implication for social work is the reminder of the importance of a biopsychosocial assessment and use of the “person in the environment” lens when assessing children who present with symptomatology mentioned here. In order to treat trauma, we must first recognize it, and be thorough in our assessments, so as to weed out other potential diagnoses that mirror that of trauma from domestic violence exposure. In this way, many social workers practicing in the mental health realm have the advantage of being trained in paradigms that ask the provider to assess the “big picture” of what is going on in the client’s life before making a diagnosis, outside of the basic medical models that other mental health providers may focus on. Additionally, the use of consultation with other professionals would be recommended to flush out misdiagnosis and accurately see the problem for what it is in situations where symptomology is complex.
A third implication for social work is the need to focus on consistency and how inconsistency impacts practice and impacts clients/ treatment effectiveness. All participants in this study emphasized the importance of consistency in treatment. While this is a seemingly assumed generalist practice, the importance of is should not go to the wayside. A recommendation as a result of this study would be for agency supervisors to track and monitor staff turnover and make efforts to reduce and minimalize this. The impacts of turnover and inconsistency on the clients, and specifically on children seeking treatment for domestic violence exposure, could be very detrimental and need to be monitored and reduced in order to implement best practice.

Conclusion

This research project sought to answer the question “What are the best practices for Social Workers treating children exposed to the trauma of domestic violence?”. The strengths of this study stand on the data derived from this study coming directly from the practitioner who work every day with children impacted by trauma from domestic violence exposure. The data comes from the people who know the conditions and circumstances surrounding the issue the best.

In completing the semi-structured interviews with professionals who work in the field treating children exposed to domestic violence, three major themes emerged; symptoms/ impacts of domestic violence exposure; age appropriate treatment recommendations for domestic violence exposure; and professionals getting the “big picture”. Much of the data from this research mirrored what was found in the literature. Important distinctions from the data in this study include the importance of a thorough assessment to get a clear idea of the “big picture” (environmental factors contributing to symptomatology) and reduce misdiagnosis of trauma;
treatment approaches that service the whole family as being highly recommended in
intervention; and consistency being a key element in the therapeutic relationship in order to
increase treatment effectiveness.

As social workers in the mental health field practicing from a “person centered” and
systems lens, this equips one well to investigate symptomatology and uncover root causes,
making accurate diagnosis. Mental health providers without training in these paradigms and
theories might be more at risk to make inaccurate diagnosis or focus on the behavior or symptom
instead of uncovering the root cause (which may be environmental verses biological). In this
way, all mental health providers need to be mindful of assessments they do, the questions they
ask, the thoroughness of their investigations, and the diagnosis that they give to child who may
not be well serviced by medication and mental health diagnosis which will stigmatized that
individual for the rest of their life, if their root cause for symptomology is indeed trauma from
exposure to domestic violence. We, as practitioners, need to be mindful of the impacts of the
environment, of domestic violence impacts, not only on the person who is physically victimized,
but also on those unseen victims- the children who witness domestic violence.

Additionally, going back to the theme of consistency as being generalist skill that is used
in therapeutic service, this study emphasizes the importance of consistency, equating it to that of
a treatment method. Children who are exposed to domestic violence deal with daily
inconsistency, and in the therapeutic work that professionals do with these unseen victims of
domestic violence, being mindful of consistency in our practice as well as in our agency, is an
important take away from this research. From a participant #4’s practice experience a quote that
highlights the importance of this in the treatment of a child exposed to domestic abuse:
He started here and was cowering in a corner. His symptoms were mainly acting out in preschool setting, really aggressive towards peers and siblings, being unable to attend to tasks for very long. And was already getting labeled as bad in school, low functioning academically, and not meeting social and emotional developmental milestones. [He] was cowering in the corner the first day of therapy and kind of like “I don’t know if I can trust you” was the message I was getting. He was trying everything out in the room for the first couple of weeks, and then he looked at me one day and for about four sessions he destroyed this therapy office we are sitting in right now. He took every figurine off the shelf, every piece out of every board game, every book off the shelf, and threw a huge pile in the room. He needed to hear over and over again, that no matter what he did, it wouldn’t change the way I felt about him, and that he could do a lot here and I was able to hold it and that he was still cared for regardless of what he did. And after that he was able to move through the play therapy stages, build a relationship with me. He was able to ask for what he needed, practice breathing, he was more regulated, he was not getting in trouble in school, and he made significant progress academically because he was able to focus because he had spaces where he could come and process. (Participant #4)
References:


National Institute of Relationship Enhancement and Center for Couples, Families and Children.

Retrieved on April 22nd 2017 from:

http://www.nire.org/professional-training-supervision-and-certification-programs/child-centered-play-therapy/


The Family Partnership. Retrieved on February 15th 2017 from:

http://www.thefamilypartnership.org/about/history/


Appendix A

*Dealing with Domestic Violence Exposure*

(Semi-Structure Interview Schedule)

**Brief description:** The purpose of this interview is to gain insight from direct practice professionals into how to best treat children who have been exposed to the trauma of domestic violence. This interview will be emailed to participant upon agreement to participant in the research study. Participant is asked to briefly complete the interview schedule attached, and come prepared to the interview to discuss in depth details of the research questions. The interview will take place in person (or via skype if distance is an issue) agreed upon location (I.e. work setting, public library, university meeting room). The length of the interview will be approximately 45 mins- 1 hour. Information derived from this research will be utilized to help identify best practice methods for dealing with children exposed to the trauma of domestic violence.

**Participant/ Service Provider Demographics:**

1. Participant Ethnicity:
2. Participant age:
3. Participant Religious background:
4. Participant job title?
5. Participant place of employment/ type of agency where practice takes place?
6. Is the agency religiously affiliated? If yes, what religious affiliation?
7. Participant length of experience in the current field?
8. Participant degree/ licensure/ credential currently held?
9. Current number of assigned cases on participants caseload?

10. Number of cases assigned that included dealing with trauma from domestic violence exposure and client is age 2-6 yrs old.

**Interview questions**

1. How does domestic violence exposure present itself in a child's daily interactions (I.e. behaviors exhibited at school, home, community)?

2. What are the impacts of domestic violence on children's mental health? Short term? Long term?

3. Are there are typical types of diagnoses that present themselves in regards to children who have been exposed to domestic violence?

4. In your professional opinion, does having a diagnosis help or hinder the child who is seeking treatment for exposure to domestic violence?

5. In your experience how does the age that the child is exposed to domestic violence impact mental health symptomatology/behaviors that are exhibited by the child?
6. Do you feel that trauma from domestic violence exposure, and trauma related incidences, should be classified as their own diagnostic category, similar to that of PTSD for adults? If so, why? If not, why not? (What would be the implications of having a separate diagnosis for children suffering from the impacts of trauma: Micro, Meso, Macro)

7. What treatment methods/ interventions methods do you currently utilize in working with children exposed to domestic violence?

8. In your experience, what treatment methods have been the most effective in working specifically with children aged 2-6 who have been exposed to domestic violence?

9. Is there anything else that you can think of that would be helpful to me and my study?
Appendix B

Invitation to Participate in Research Project

Greetings,

You have been referred as a potential participant to a research project on interventions and treatment for children aged 2-6 exposed to domestic violence by (name of referring person). This research project is being conducted as a graduate level course requirement in order to satisfy the guidelines for the Graduate Program of joint School of Social Work at the University of St. Thomas & St. Catherine’s University.

This research project consist of interviews with professionals who work directly with children experiencing trauma from domestic violence exposure. The research consist of a semi-structure interview with professionals to determine best methods of intervention and treatment for children exposed to domestic violence. You have been identified as a potential candidate for this interview.

If you are interested in participating please review the following participant requirements:

Interview subjects must have the following qualifications to participate in this study:

1. Master’s level degree in Mental Health Services (I.e. MSW, LICSW, LMFT, LPC, LPCC, or LADC).
2. Professional experience in the field for a minimum of 1 year.
3. Working at least 50% (carrying a caseload of 50% or more) of the time with children who have experienced trauma aged 2-6.
4. Be able to commit to a 60-75 minute interview with researcher.

If you are interested in participating in this research, your response would be greatly appreciated and the researcher Sarah Callahan will contact you with follow up paper work and to schedule an interview time.

If you are unable or uninterested in participating in this research, but know another qualified professional who might be interested, the researcher would greatly appreciate any potential referrals.
Please respond via email within 3 business days to confirm or deny your interest in this research.

Thank you!

Sarah Callahan
Researcher with Graduate School of Social Work joint program with University of St. Thomas, and St. Catherine's University.
Email: call7784@stthomas.edu
Phone: (612)978-2223
Appendix C

ST CATHERINE UNIVERSITY
Informed Consent for a Research Study

Study Title: Domestic Violence: How to Treat the Unseen Victims

Researcher(s): Sarah Callahan, B.S.W.

You are invited to participate in a research study. This study is called Domestic Violence: How to Treat the Unseen Victims. The study is being done by Sarah A. Callahan, a Masters’ level student at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Michael G. Chovanec, Ph.D., LICSW, and a Professor in the School of Social Work at St. Catherine University.

The purpose of this study is to answer the research question “What are the best methods of practice for working with children aged 2-6 years old, who have been exposed to domestic violence and are experiencing mental health complications?” This study is important because little research has been done on best practice treatments in working with young children whom are dealing with trauma from exposure to domestic violence. Approximately 8 people are expected to participate in this research. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why have I been asked to be in this study?

You have been selected for participation in this research project because another professional in the community identified you as a professional that works with children exposed to violence. In order to qualify as a participant you must meet the following criteria:

* Master’s level degree in Mental Health Services (I.e. MSW, LICSW, LMFT, LPC, LPCC, or LADC).
* Professional experience in the field for a minimum of 1 year.
* Working at least 75% (carrying a caseload of 75% or more) of the time with children who have experienced trauma related to domestic violence exposure aged 2-6.
* Be able to commit to a 1 hour interview with researcher.

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, the researcher will contact you for screening to ensure you meet eligibility criteria for this research study. This should take about 10 minutes of your time, during which time, if you are deemed eligible, you will be asked to schedule an interview. The interview data will be used for the purpose of this research. Interviews will be recorded for later transcription of data. Interviews are estimated to take between 45mins to 1 hour in length.

What if I decide I don’t want to be in this study?
Participation in this study is completely voluntary. If you decide you do not want to participate in this study, please feel free to say so, and do not sign this form. If you decide to participate in this study, but later change your mind and want to withdraw, simply notify me (Sarah Callahan). If you decide to withdraw from participation in this study at any point during the actual interview, simply notify the interviewer (Sarah Callahan), at which time we can then end the interview. Your decision whether or not to participate will have no negative or positive impact on your relationship with St. Catherine University, or with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

Potential risk for the participants of this survey is minimal. Risks include possible disclosure of information relating to participants work that might negatively frame the agency in which they are employed. Participants may fear that information given in the research interview may get back to their supervisors, thus negatively impacting their employment. For this reason, participants may refuse to answer any question that makes them uncomfortable. Additionally the researcher will work to provide strict confidentiality of research participants; all identifying information will be omitted or changed (place of employment and names of participants).

What are the benefits (good things) that may happen if I am in this study?

A major strength of this study is that the research is coming from practitioners- from the source of the work that is being done. Interviewing practitioners about best methods for treatment of children impacted by domestic violence exposure will give the “front of the line” perspective and expertise from those who know the work first hand and deal with it daily. The practitioners interviewed for this research study will be experienced in the work they do with their clients, and what treatment methods are most effective and/ or least effective. Compiling and analyzing treatment methods of seasoned practitioners, and determining best practice recommendations for children aged 2-6 years old dealing with trauma of domestic violence exposure will greatly benefit the field of practitioners serving this population.

Will I receive any compensation for participating in this study?

You will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in this study will be transcribe from audio recordings of the interview. Each participant will have their name removed from the data and replaced by an assigned number that only the research knows the responding participant to. I will keep the research results in password protected computer documents/ audio files and transcription paper copies in locked filing cabinets and only I and the research advisor will have access to the
records while I work on this project. I will finish analyzing the data by May 1st 2017. I will then destroy all original reports and identifying information that can be linked back to you by June 1st 2017. All audio recordings will be accessible only to the researcher, and will be erased or destroyed by June 1st 2017.

Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in any written reports or publications. If it becomes useful to disclose any of your information, I will seek your permission and tell you the persons or agencies to whom the information will be furnished, the nature of the information to be furnished, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not grant permission, the information will remain confidential and will not be released.

**Are there possible changes to the study once it gets started?**

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

**How can I get more information?**

If you have any questions, you can ask them before you sign this form. You can also feel free to contact enter me (Sarah Callahan) via phone/ text message @ (612)978-2223 or via email @ call7784@stthomas.edu. If you have any additional questions later and would like to talk to the faculty advisor, please contact Michael G. Chovanec via phone @ (651)690-8722 or via email @ mgchovanec@stkate.edu. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

**Statement of Consent:**

I consent to participate in the study and agree to be audiotaped.

My signature indicates that I have read this information and my questions have been answered. I also know that even after signing this form, I may withdraw from the study by informing the researcher(s).

________________________________________________________________

Signature of Participant Date
DOMESTIC VIOLENCE HOW TO TREAT THE UNSEEN VICTIMS

Signature of Researcher       Date