What Children Exposed to Intimate Partner Violence Need to Heal

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Abstract

Children who are exposed to intimate partner violence (IPV) experience many negative effects linked to their experience with violence. Although there are a lot of interventions to help assist children recover from the traumatic events of IPV, very few are evaluated for their effectiveness. Through research and evaluated interventions, including a community-based program and the Preschool Kids Club (PKC) the characteristics that are important in creating a successful invention program are investigated. Characteristics include creating resiliency, choosing educational topics, important skills to build, types of therapy, and treatment of the mother. It is discovered that taking a holistic approach is best for impacting change in both the child effected by exposure to IPV and the mother who experienced IPV.

Keywords: Children, intimate partner violence, interventions, outcomes

Introduction

Exposure to intimate partner violence (IPV) has several negative effects on children that can be lessened through intervention. While there are many interventions for children who are exposed to IPV, there is not a set of best practices that indicate the important aspects of these interventions. Various characteristics are important to consider when creating an intervention to
diminish the consequences of children exposed to IPV, such as the impact of resiliency, the education topics, what skills are important to build, the type of therapy, and the involvement of mentors and parent(s). While the characteristics are fairly stable across age, the manifestation of these characteristics should change based on age of the child. While it is important to consider these characteristics individually, it is also important to consider the impact of these characteristics together, to create a holistic approach. To start, consequences of exposure to violence will be discussed to highlight the importance of intervention.

Consequences

Exposure to intimate partner violence can have a range of short and long-term consequences. Exposure to IPV affects the child's emotional well-being, including feelings of guilt and self-blame (Groves, 1999; Holt, Buckley & Whelan, 2008; Stern, 2014). Children who have been exposed to IPV may also have difficulty processing emotional cues (Vickerman & Margolin, 2007). The child's mental health can be affected. This can include PTSD symptoms, depression symptoms, and a range of psychiatric disorders (Groves, 1999; Holt et al., 2008; Overbeek, Clasien de Schipper & Lamers-Winkelman, 2013; van Heugten & Wilson, 2008). The problems that children experience often manifest themselves in behavioural problems (Holt et al., 2008; Overbeek et al., 2013; van Heugten & Wilson, 2008).

Being exposed to IPV affects relationships throughout the lifespan, including relationship with parents, partners, and peers. The child's relationship with both parents is very complex, because of the mixed emotions and feeling towards both parents, one for perpetrating violence, the other for letting it happen (Stern, 2014; Holt et al., 2008). Forming intimate and peer relationships is often difficult because of the lack of trust (Holt et al., 2008; van Heugten & Wilson, 2008). Trust is important in the building of relationships, as trust allows people to open up about themselves, and believe that the other person will not hurt them, but after being exposed to IPV this trust can be difficult to develop (Larzelere & Huston, 1980). Additionally, exposure to IPV increases the likelihood that future relationships will involve violence, whether the witness is now the primary victim or is now the perpetrator, continuing the cycle of violence (van Heugten & Wilson, 2008).

A child may not only be exposed to IPV, but also be a victim of violence from one or both parents. The co-occurrence of exposure and experiencing violence has increased consequences (Dube, Anda, Felitti, Edwards & Williamson, 2002; Holt et al., 2008; van Heugten & Wilson, 2008). The impact of multiple adverse childhood experiences can increase the likelihood of experiencing problems associated with exposure to IPV, or can increase risk for other issues, such as alcoholism and depression (Dube et al., 2002). Overall, exposure to violence affects the child's social, emotional, and cognitive development (Groves, 1999).

Interventions

Two intervention programs will be discussed throughout the paper. The first is the Preschool Kids Club (PKC) (Graham-Bermann, Miller-Graff, Howell & Grogan-Kaylor, 2015; Howell, Miller, Lilly & Graham-Bermann, 2013). This intervention included a portion for the child (PKC) and a portion for the mother, the Mom's Empowerment Program (MEP). The PKC
program was targeted towards 4-6 year olds and involves 10 sessions that last approximately an hour. Each session discusses a topic related to exposure to IPV, for example, safety plans, feelings about violence, and conflict resolution. The sessions were done in a group format. The MEP program was meant to improve the mothers social and emotional adjustment after experiencing IPV, which was done by normalizing and reducing distress, providing support and helping to improve parenting. There was a focus on positive aspects and the impact that violence has on their child. The therapists in the intervention were master's-level students and community social workers who received intensive training in work with children and women who have experienced IPV. Additionally, they were supervised by the clinical psychologist who created the intervention (Graham-Bermann et al., 2015; Howell et al., 2013).

The second intervention was a community-based program evaluated by Sullivan, Bybee, and Allen (2002). This program involved the mothers getting a free advocate for 16 weeks, who helped with accessing community resources, for example legal assistance, housing, and employment. Additionally, the advocate gave the mother the skills and knowledge they needed. This assistance was tailored to what the mother needed. The children, who were 7-11 years old, participated in a 10-week support and education program. The education was on topics such as respect, feelings, and safety. The activities aimed to use physical activity to teach these lessons. Advocates were extensively trained undergraduate students. The women and children reported high satisfaction with the program (Sullivan et al., 2002).

It is important that an intervention for children who have been exposed to IPV be holistic. As highlighted earlier, there are many areas in which there can be consequences for children who have been exposed to IPV which need to be addressed. While there have been many programs evaluated that are based on one single area, for example a program to deal with PTSD, there are few intervention programs for IPV as a whole that have been evaluated. Different types of interventions deal with different areas, so an intervention program for children exposed to IPV should include various elements to ensure that all these areas are covered. A holistic approach that looks at the bigger picture allows for a range of issues to be dealt with. This is key, as it is unrealistic to have separate interventions for each different area in which there are consequences.

Age plays a large role in the creation of programs, as different age groups will need different approaches. There tend to be three different age brackets, preschoolers, which includes 4-6 year olds, children, which includes 6-12 year olds, and adolescence, which includes 12-18 year olds. Currently, most research on the characteristics of interventions focuses on children, while intervention program assessments focus on preschoolers and children. Having different interventions for different age groups will help children exposed to IPV to get more out of the program, as it will be geared more towards their needs and understanding levels. While the characteristics needed in an intervention are the same, the approach should be different.

Resiliency

One goal of interventions should be to create resilient children. Resiliency is the ability to overcome adversity (Howell, Graham-Bermann, Czyz & Lilly, 2010; van Heugten and
Wilson, 2008; Willis, Hawkins, Pearce, Phalen, Keet & Singer, 2010). Resiliency is beneficial in the healing process of children of all ages who have been exposed to IPV because resiliency creates strategies that can be used throughout the lifespan (Anderson & Danis, 2006; Howell et al., 2010). Creating resiliency is vital because it is related to a commitment to escape the cycle of violence, which can help to decrease future family violence (Anderson & Danis, 2006; Stern, 2014). Resiliency can also help to decrease some of the consequences of exposure to IPV, including behaviour problems and feelings of powerlessness (Anderson & Danis, 2006; Howell et al., 2010; Stern, 2014).

Studies about resiliency in preschoolers and children have found three main factors that predict resiliency: violence severity, maternal health, and parenting (Howell et al., 2010). Violence severity and resiliency had a negative correlation, indicating that as severity increases resiliency decreases (Graham-Bermann, Gruber, Howell & Girz, 2009; Howell et al., 2010). It has been found that a child is more likely to be resilient if the mother has good emotional health or good parenting skills (Graham-Bermann et al., 2009; Howell et al., 2010). Additionally, parental warmth has been found to be key in distinguishing children who struggle, from children who are resilient (Graham-Bermann et al., 2009). This may be because the child has help in managing their behaviour and is provided with positive role model, which is important for children, particularly who have been exposed to IPV (Graham-Bermann et al., 2009).

Therefore, improving the mother’s health and parenting skills may assist in building resiliency. One way to do this is to also give the mother treatment, which will be discussed later (Anderson & Danis, 2006).

Children often feel a sense of being powerless when exposed to IPV, but resisting powerless feelings can help develop resilience (Anderson & Danis, 2006). Two categories of resistance have been found; withstanding involves protecting themselves while, opposing involves trying to prevent or stop the violence (Anderson & Danis, 2006). Children who are exposed to IPV tend to use a combination of both strategies (Anderson & Danis, 2006). Withstanding strategies include creating escapes, such as a safe place in their room, trying to understand what was happening, building support networks, and realizing they have power in other areas (Anderson & Danis, 2006). Opposing strategies included intervening and comforting their parent or siblings after. Additionally, having and using a safety plan is an opposing strategy (Anderson & Danis, 2006). A safety plan involves identifying cues, knowing who can help, and protecting their own safety (Vickerman & Margolin, 2007). Having a safety plan involves using coping and problem-solving skills, which is a large part of resilience, meaning improving these skills can increase resiliency (van Heugten & Wilson, 2008). Both the PKC program and the community-based program evaluated by Sullivan et al., (2002) discussed safety plans.

Children are not always aware that they are taking back power through using these resistant strategies, so informing them that these strategies are good assists in the process of building resiliency (Anderson & Danis, 2006). Other ways to increase resilience include improving self-confidence, self-acceptance, and competence (van Heugten & Wilson, 2008). Both the PKC and community-based program evaluated by Sullivan et al., (2002) saw an increase in competence of participants (Howell et al., 2013). Additionally, children who were involved in the community-based program evaluated by Sullivan et al., (2002) had increased
global self-worth at the four month follow-up.

**Characteristics**

Education about IPV and violence more generally is important to healing. Education helps the victims develop coping strategies and understand the violence differently, which helps them gain control they feel they have lost (Vickerman & Margolin, 2007). Many children feel that the violence is their fault, so part of education is teaching them that the violence between their parents is not their fault. Additionally, that they are not responsible for dealing with the violence (Groves, 1999; Stern, 2014; Vickerman & Margolin, 2007; Willis et al., 2010). To drive this point home, it may be helpful for children to understand the reasons why their parents fight (Vickerman & Margolin, 2007).

Children also need to be taught that violence in intimate relationships is not normal and that it is not right (Anderson & Danis, 2006; Vickerman & Margolin, 2007). While some children already realize that the violence is not normal, many believe that violence is the way people in all relationships deal with problems (Anderson & Danis, 2006; Vickerman & Margolin, 2007). A broader understanding of violence and its consequences may help children understand that violence is not the way to deal with problems (Willis et al. 2010). The PKC program teaches gender role beliefs in relationships and positive attributes of families as part of this broader understanding of violence (Howell et al., 2013). Overall, this deeper understanding of violence will help to address the assumptions children have about violence and give them a vocabulary that they can use in the future (Vickerman & Margolin, 2007). Although most research in this area is on children, a lot of the content could also apply to both preschoolers and adolescence but would have to be taught differently based on age group. For example, using puppets to teach preschoolers versus using a lecture format for adolescence.

Children need to understand that violence is a choice and is not an acceptable way to deal with conflict (Vickerman & Margolin, 2007). For this idea to be able to stick, conflict resolution skills must be taught (Groves 1999). These skills allow children to find an alternative to physical fighting. The PKC program aimed to teach the preschoolers how to resolve differences without the use of aggression. This was done through brainstorming and acting out their ideas (Howell et al., 2013). Other skills that will help children deal with conflict include: anger management, appropriate behaviour and responses, assertiveness, and communication skills (Groves, 1999; Willis et al., 2010). Additionally, stress management and problem-solving skills are important to teach as these skills can help with coping (Vickerman & Margolin, 2007; Willis et al., 2010). A large tool box of coping skills is also needed, so that the children can deal with their situation. Some coping skills that may assist are relaxation, positive imagery, self-talk, and thought stopping (Vickerman & Margolin, 2007). If children who have been exposed to IPV are able to understand that they control their thoughts and that they do not need to be consumed with thoughts of violence, they will be able to heal (Vickerman & Margolin, 2007).

As stated earlier, difficulty processing emotional cues can be a consequence of exposure to IPV. Learning how to regulate emotions can assist them in understanding and coping with their responses to the violence (Groves, 1999; Howell et al., 2010; van Heugten & Wilson, 2008). Children should learn to identify, accept, and effectively communicate their emotions,
particularly anger (Ermentrout, Rizo, & Macy, 2014). One way to learn to regulate emotions is to discover the body sensations experienced during different emotions (Vickerman & Margolin, 2007). Children exposed to IPV in the home may have confusing and varied feelings towards both parents, and nowhere to put the emotions (Groves, 1999). To give children an outlet, children can become involved in activities where they can express their emotions in a productive way. Examples of activities include: music, art, dance, sports, writing, and pet or sand trays (Stern, 2014; Willis et al., 2010).

Both the PKC and the community-based program evaluated by Sullivan et al., (2002) programs work to teach emotion regulation. The PKC program allowed the preschoolers to express their emotions through the arts and assists in developing a language which can be used to discuss feelings and emotions (Howell et al., 2013). The community-based program evaluated by Sullivan et al., (2002) worked to educate children on their feelings through fun physical activities. Graham-Bermann et al., (2015) found that the PKC program significantly decreased internalizing problems, such as withdrawal and depression, in female preschoolers that had attended the PKC program at the eight month follow-up. The program also decreased the amount of preschoolers who were in the clinical range for internalizing problems at the beginning of the intervention with 23% no longer in the clinical range eight months later. This is compared to only eight percent of children in the control group.

Children want a supportive mentor, particularly one who has been through a similar situation (Vickerman & Margolin, 2007; Willis et al., 2010). It is important that children have role models for what a healthy relationship looks like in order to be able to develop their own healthy relationships (Willis et al., 2010). Having a mentor is a helpful aspect for all ages, but may look a little different with the different ages. There are a number of different ways this could look, one way would include having the program help connect children with mentors to help them get through difficult times. With preschoolers it may be best to have one-on-one mentors, while children and adolescents would be able to share their mentor and it may be best to have the mentor lead a group intervention. In order to help children develop some of the previously discussed skills, it may be beneficial for the children to see the skills modeled by a mentor.

Therapy

Therapy is a key feature in interventions, as just the act of disclosing the trauma can be helpful (Overbeek et al., 2013; Stern, 2014). There are one-on-one treatments and group treatments. As mentioned before a holistic approach is valuable, so having both one-on-one and group treatments may be best. The two treatments have different purposes, so having both allows for more areas of consequence to be covered. One-on-one therapy allows for attention to specifically be paid to that child, and their traumatic cues, distorted thoughts, and behavioural interactions (Vickerman & Margolin, 2007).

Group treatments allow children to create relationships with their peers (Howell et al., 2013). This is important because, as discussed earlier, exposure to IPV affects relationships throughout the victim’s life, so being able to rebuild trust in others is beneficial. Children will also see they are not alone in their experiences (Willis et al., 2010). While interventions can
teach that children are not alone and the violence is not their fault, seeing others in similar situations and being able to share their beliefs, attitudes, and reactions to IPV can be valuable (Vickerman & Margolin, 2007). It is also important that children understand that the symptoms they are experiencing are normal for their circumstances. Again, this validation can be found in group settings where children can see that they are not alone, and that there are other children in similar situations, who have similar symptoms (Vickerman & Margolin, 2007). Ermentrout et al., (2014) found that this environment did create peer bonding and that it reinforced the fact that the children are not alone.

Both the PKC and the community-based intervention evaluated by Sullivan et al., (2002) used a group-based approach. In PKC the first few sessions are used to create a safe space and allow the preschoolers to bond (Howell et al., 2013). Qualitative research has found that it is important to mothers that their child has a safe space to discuss the impacts of IPV (Ermentrout et al., 2014). The outcome of the PKC program was an increase in prosocial skills. The preschoolers who attended PKC had a significant increase in their prosocial scores from pre-intervention to post-intervention, while those in a control group did not. This finding was greater for preschoolers who had more prosocial skills to begin with (Howell et al., 2013).

Group therapy interventions should be grouped based on age brackets, as preschoolers, children, and adolescence all have different needs and ability levels (Groves, 1999). Some studies find groups are not as useful for preschoolers as they are less focused and do not use peer relationships as a coping strategy as much as children (Groves, 1999). Others say groups for preschoolers need to be focused on play (Vickerman & Margolin, 2007; Willis et al., 2010). Children and adolescents are able to understand problem solving, violence education, and safety planning (Willis et al., 2010). Adolescent groups should be more adult-oriented, but also cater to adolescent problems, such as adjustment problems, risk taking, and social pressure (Vickerman & Margolin, 2007).

The other comparison in therapy is specific factors, such as trauma, versus non-specific factors. Although both types have been found to decrease symptoms, some studies have found that for children who have been exposed to IPV, symptoms decrease at a faster rate with non-specific therapy (Overbeek et al., 2013; Vickerman & Margolin, 2007). This shows that for children who have been exposed to IPV, a trauma focus is not required, and may even have less value because the children are dealing with additional stressors (Overbeek et al., 2013). This comes back to the idea of having a holistic approach to deal with the multiple consequences of being exposed to IPV. One technique in trauma focus therapy that may be useful is re-exposure. Re-exposure is a desensitization process in which the event and aversive stimuli surrounding the event are discussed. If children are avoiding anything that has cues that are also present during violent episodes, this technique may be helpful, as it reduces physiological and psychological responses to cues, so that the child no longer has to avoid them (Vickerman & Margolin, 2007).

**Inclusion of Parents**

Treatment for the mother can indirectly help the child who has been exposed to IPV. It has been found that when the mother is receiving treatment as well as the child there is a long-
term decrease in behavioural problems and a positive change in children's beliefs about violence (Grahman-Bermann et al., 2007). The benefits of treating the mother can be seen in the results from both interventions, where there were improvements in the children, some of which could be accounted for because of the mothers’ intervention (Graham-Bermann & Miller-Graff, 2015; Sullivan et al., 2002). The importance of the mothers’ treatment is clear in the results from the PKC program, in which it was found that children’s positive outcomes, specifically increased prosocial behaviour, were higher for children who had less negative parenting and whose mothers’ were less depressed (Howell et al., 2013). Additionally, the community-based program evaluated by Sullivan et al., (2002) found an increase in mothers’ general well-being and self-esteem as well as a decrease in depression symptoms (Sullivan et al., 2002). Overall, treatment for parents has been seen to decrease children's consequences and mothers distress (Vickerman & Margolin, 2007).

A holistic approach to interventions for children who have witnessed IPV, should include treatment for the mother. There are three important aspects to note when treating mothers, which are improving parenting, education and dealing with stressors. While these are important aspects individually, they do overlap. Graham-Bermann and Miller-Graff (2015) found that depression impacts parenting skills and taking time to deal with stressors can take time away from the child.

Improving parenting skills can be done by stopping aggressive parenting, improving positive parenting and increasing maternal responsiveness (Vickerman & Margolin, 2007). One of the goals of the MEP portion of the PKC program was to help mothers parent under stress which included problem solving parenting challenges. Results from this program showed that there were short-term significant increases in positive parenting, which was not seen in the control group (Graham-Bermann & Miller Graff, 2015). The second aspect is information about how to help the child. Knowing some strategies to help their child cope, learning about how to speak to their child about violence, and being aware of the impact the IPV is making in the child's life is important in helping parents aid their child in the healing process (Groves, 1999; Vickerman & Margolin, 2007; Willis et al., 2010). In the MEP sessions the impact of IPV on children’s development and functioning is discussed (Howell et al., 2013).

The final aspect is dealing with stressors in the mothers’ life, such as isolation (Groves, 1999; Stern, 2014; Vickerman & Margolin, 2007). Stress and anger management may assist in helping mothers take control of their lives (Vickerman & Margolin, 2007). The difficulties the parent is having affects the child. These difficulties can increase PTSD symptoms in the child and leaves less time to be spent with the child (Stern, 2014; Vickerman & Margolin, 2007).

The community-based program evaluated by Sullivan et al., (2002)’s main objective was to assist in getting mothers the supports they needed, such as goods and services, social support and child care. The MEP portion of the PKC program also helped mothers find social support and community resources. Additionally, the MEP program worked to reduce mothers’ distress and mental health issues (Howell et al., 2013). Both programs found similar results in changes for the mother. They found that the mother’s depression levels decreased, which lasted to the follow-up (4-8 months later; Graham-Bermann & Miller-Graff, 2015; Sullivan et al., 2002). Sullivan et al., (2002) also found that mothers’ self-esteem increased long-term. As with
these programs other programs would benefit if treatment for mothers was held at the same time as treatment for the children, to assist with time management (Willis et al., 2010).

In addition to the mother getting treatment, involving her in the treatment may also be beneficial. Involving the mother in treatment is favourable for children of all ages (Overbeek et al., 2013; Vickerman & Margolin, 2007). Joint and individual therapy sessions will help to keep up or repair the bond between mother and child (Groves, 1999; Vickerman & Margolin, 2007). Children may be angry or resentful with their mother because of the decisions that led to the child’s exposure to IPV, or for their mother not protecting them (Stern, 2014). Involving the mother also allows the parent and child to create a joint trauma narrative (Stern, 2014; Vickerman & Margolin, 2007). In addition to including the mother, including the offending parent (usually the father) is also something to consider if the father continues to interact with the child (Groves, 1999; Vickerman & Margolin, 2007). The involvement of the father is complicated and should be based on the family’s specific situation. If the father is involved, it is important to take precautions in order to protect the family; these precautions include keeping the parents separate and having multiple therapists (Groves, 1999). Children may be angry or resentful towards their father for perpetrating the violence. The goal in including the parent(s) is to reduce risk to the child and help them heal (Vickerman & Margolin, 2007).

Conclusion

With the many consequences children who have been exposure to violence endure, it is important to make interventions that help them in all aspects. There are many characteristics that need to be considered when creating a program for children who have been exposed to IPV including, resiliency, educational topics, skill building, types of therapy, and treatment or involvement of parent(s). Education is a key component of interventions. Teaching children about violence gives them a better understanding and allows them to strive to not have violence in their own relationships. Additionally, building a tool box of skills that they can use to cope and deal with the problem at hand will allow them to be better prepared for their future. Considering the different aspects of therapy will encourage the development of ideal programs. Everything leads towards making children who are exposed to IPV more resilient, a trait they will bring with them throughout life.

Taking a holistic approach that works to decrease the consequences of exposure to IPV is best. The PKC program and a community-based program evaluated by Sullivan et al., (2002) were used as examples to show the impact of a holistic approach. These two programs saw an increase in the participants competence, self-worth, and prosocial skills, as well as, a decrease in internalizing problems (Graham-Berman & Miller-Graff, 2015; Graham-Bermann et al., 2015; Howell et al., 2013; Sullivan et al., 2002). The programs also treated mothers, where they saw improvements in the children and the mothers. Mothers well-being, self-esteem, and positive parenting skills increased, while depression symptoms decreased. Overall, it is clear that a holistic approach that aims to decrease the consequences of exposure to IPV is the best approach to take for both child and mother.

References


