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Children Who Witness Violence: What Services Do They Need To Heal?

Danny Willis, DNS, RN, PMHCNS-BC and Joellen W. Hawkins, PhD, RN, WHNP-BC, FAANP, FAAN
Boston College, William F. Connell School of Nursing, Chestnut Hill, Massachusetts, United States

Carole W. Pearce, PhD, RN, WHNP-BC
University of Massachusetts Lowell, Nursing, Lowell, Massachusetts, United States

Jaime Phalen, MS, RN, WHNP-BC
Crown Obstetrics and Gynecology, Quincy, Massachusetts, United States

Meredith Keet, MS, RN, WHNP-BC
Private Office, Walnut Creek, California, United States

Cristen Singer, MS, RN, WHNP-BC
Women First OB/GYN, Louisville, Kentucky, United States

Children are witnesses to violence far too often in their daily lives. To elicit information on the needs of children and adolescents living in the United States who have witnessed violence in their homes, neighborhoods, or communities, we held focus groups with mothers who have survived interpersonal violence and whose family included child witnesses to violence (CWV), professionals who work with families affected by violence, and with adolescents who have witnessed violence. Based on four separate focus group discussions held in Massachusetts, involving a total of 45 participants, recommendations for screening, programming, and the development of healing interventions are offered to mental health professionals.

Screening, program development, and interventions based on the real and multifaceted needs of children who witness violence can help facilitate these children's humanization, choice, meaning, quality of life, and healing, all of which are the central goals of nursing (Willis, Grace, & Roy, 2008). Thus, the aim of this research was to elicit information in focus groups about interventions that participants with personal and professional experiences with children who are witnesses to violence (CWV) believe might be helpful for the children, adolescents, and their families. Research about CWV is highly significant to mental health nursing practice as children are witnesses to violence in their communities, homes, neighborhoods, schools, and playgrounds, as well as through violent crimes and activities of street gangs and drug dealers. According to prevalence estimates, 50–86% of children and adolescents living in urban areas are exposed to violence in their neighborhoods, ranging from drug deals to stabbings and shootings (Fowler, Tompsett, Braciszewski, Jacques-Tirua, & Baltes, 2009) and also in their schools (Janosz, Archambault, Pagani, Pascal, Morin, & Bowen, 2008). Perhaps as many as one in ten children are witnessing violence and half of these are witnessing violence in their homes, according to the work of a team of researchers at Boston Medical Center (Groves, Zuckerman, Marans, & Cohen, 1993; Taylor, Zuckerman, Harik, & Groves, 1992; Zuckerman, Augustyn, Groves, & Parker, 1995). The groundbreaking work on CWV at Boston Medical Center was done in the early 1990s, and continues to be a model of CWV services, thus references to this earlier work are included for historical purposes. The frequency and severity of domestic violence and the realization that children are often aware of these incidents, have prompted researchers over the more than 25 years to address the effects of witnessing domestic violence (DV) on children and adolescents (Riger, Raja, & Camacho, 2002; Spilsbury, Kahana, Drotar, Creeden, Flannery, & Friedman, 2008).

Address correspondence to Danny Willis, Boston College, William F. Connell School of Nursing, 140 Commonwealth Ave., 336D Cushing Hall, Chestnut Hill, MA 02467. E-mail: danny.willis@bc.edu

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THE LITERATURE: BACKGROUND FOR THE STUDY

Prevalence of Violence

Children are frequently present during violent incidents that occur in their homes and may hear or witness events, or themselves be harmed or threatened (Edleson, 1999b; Tajima, 2002). Estimates of the number of children who witness DV in their homes each year range from 3.3 million to as high as 10 million (Rudo, Powell, & Dunlap, 1998). More recently, Gjelsvik, Verhoek-Oftedahl, and Pearlman (2003) reported from their sample of 2,751 children witnesses that 47% ($n = 1,289$) of the children who witnessed violence in their homes were less than 6 years old, 36% ($n = 984$) were 6 through 11 years old, and 17% ($n = 478$) were 12 through 17 years old.

Consequences of Violence

Children often witness intimate partner violence (IPV) and domestic violence (DV) and that violence has many effects on those children. IPV has been defined as "threatened or actual physical, psychological, emotional or sexual abuse directed toward a current or former intimate partner" (United States Center for Injury Prevention and Control, 2003a, b). DV has been defined by the National Center for Victims of Crime (2010): "domestic violence constitutes the willful intimidation, assault, battery, sexual assault or other abusive behavior perpetrated by one family member, household member, or intimate partner against another." The effects on children from witnessing violence have been documented in more than 100 studies to date (Attala, Bauza, Pratt, & Vieira, 1995; Campbell & Lewandowski, 1997; Carter & Stevenson, 1999; Edelson, 1999a, 1999b; Feerick & Silverman, 2006; Glodich, 1998; Groves, Augustyn, Lee, & Sawires, 2002; Kolbo, 1996; Rudo et al., 1998; Sox, 2004; Spilsbury, et al., 2008; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Children growing up with violence in their homes and communities learn about the role of violence in interpersonal relationships. Some child witnesses come to view violence as an integral part of loving and reflect this perception in their behavior toward others (Sims, Dodd, & Tejeda, 2008; Spaccarelli, Coatsworth, & Bowden, 1995).

Interventions at the Community, Family, and Individual Levels

The CWV program established at Boston Medical Center in 1992 is a national model for intervention targeted at intervening with young children (Groves, 2002). Recommendations from 18 years of experience can serve as guidelines for those creating and adapting programs for individual communities. With the Boston Medical Center Program as an exemplar, it becomes clear to interventionists that goals for community coalitions are separate from—but linked to—individual and family level interventions that ultimately create a comprehensive intervention matrix for promoting resilience. In discussing CWV interventions and fostering resilience in children, Groves and Gewirtz (2006) defined resilience as "children's ability to function adequately despite considerable adversity" (p. 114), and proposed that "the complex interplay between child and environment means that children may be vulnerable at some points and resilient at others" (p.115). Thus, interventions are centered on addressing concerns about CWV at multiple levels that influence the children's prospects for resilience. For example, at the level of the family and community, it is critical to address the needs of parents and involve other adults in the community who have frequent contact with children and play significant roles in their lives, such as teachers, school nurses, counselors, social workers, and health care professionals providing pediatric and mental health care. A central component of intervention at the individual, family, and community level involves advocating for children's well-being, safety planning, and the right to have basic needs met (Ernst, Weiss, Enright-Smith, & Hansen, 2008; Peled & Davis, 1997), as well as creating "a social climate that makes violence against women and children unacceptable" (Groves, 2002, p. 135). Groves and Gannon (2000) described a model that included multidisciplinary training to foster community awareness and create the environment for collaboration. Similarly, Osofsky (2003) has posited an ecological systems model for both prevention and intervention, stressing the importance of involving resources and support from various groups in children's environments, including schools, police officers, and community agencies and institutions.

Individual (Ernst, Weiss, Enright-Smith, & Hansen, 2008; Groves & Gannon, 2000), family systems (Groves & Zuckerman, 1997), and group (Peled & Davis, 1995) interventions are helpful for the child witness to violence as parts of the comprehensive intervention matrix. Consistent with the ideas presented above, Groves and Zuckerman (1997) pointed out the need for interventions for parents and other caregivers of children who witness violence in addition to individual level intervention with children. Individual interventions with young children may focus on play while older children and adolescent intervention may be more appropriately focused on cognitive restructuring, problem solving, safety planning, and violence education (Vickerman & Margolin, 2007). Lieberman, Van Horn, and Ippen (2005) have reported positive findings for reductions in posttraumatic stress disorder (PTSD) symptoms in both children and parents/mothers exposed to DV when treating with Child-Parent Psychotherapy (CPP). Jaffe, Cooks, and Wolfe (2003) emphasized safety planning, accountability, and early intervention for children exposed to domestic violence. However, in addition to individual treatment, they urged the creation of new models for engaging in systems changes and a hold on these changes, such as holding off on legislation aimed at children who are witnesses to violence until the implications can be thoughtfully analyzed and a plan for evaluation created. Ernst, Weiss, Enright-Smith, and Hansen (2008) evaluated a CWV individual-level intervention program in a large Hispanic city and concluded that intervention including individual and group approaches is important to educate children who witness

violence, help them understand that violence is not their fault, and plan for future events in which their safety is compromised (develop safety plans). Components of the intervention program they evaluated included children's art, and pet and sand tray therapies, as well as the use of coloring books that helped children develop their future safety plans. The intervention program was found to have positive outcomes for helping children who witness violence, including significant improvements from pre-intervention to post-intervention in terms of the children's awareness that violence was not their fault and their ability to plan for their future safety.

Cultural Differences and Political Support Relevant to Interventions

Cultural differences are important to consider when planning interventions for children. Attendees at the 2003 National Institute of Child Health and Human Development (NICHD) workshop on children exposed to violence, including nurse researchers Dr. Jacquelyn Campbell, of Johns Hopkins University, and Dr. Janice Humphries, of University of California San Francisco, recommended involving subjects or the target community in planning interventions, taking care that interventions are ethnically and culturally appropriate. Gjelsvik et al. (2003) found that incidents of IPV involving Hispanic and black women victims were more likely to have a child witness compared with incidents with white women victims. Cultural differences also influence children's perceptions of domestic violence. These perceptions may affect the manifestation of children's behaviors and their physical and emotional problems. Furthermore, Smith and colleagues (2002) cited the importance of having political support for programs, as well as designing interventions through a coalition of care providers and agencies. They emphasized commitment from community agencies and individuals, linking mentoring programs in the community such as Girl and Boy Scouts, school-based programs, the Girls and Boys Clubs, and other similar agencies. Fowler, Toro, Tompsett, and Baltes (2009) explored the role of parental monitoring on adolescents' externalizing of problems when they are exposed to community and family violence.

Identified Knowledge Gap in the Literature

The literature is missing information about the needs of and services for child witness to violence survivors and their parents (usually mothers) from the perspective of those directly involved: mothers, children, and professionals who care for them (Lemmey, McFarlane, Willson, & Malecha, 2001; NICHD, 2003). Involvement of the mothers in programs seems critical so that there can be change for their children (NICHD, 2003). This involvement might begin with asking mothers what they believe are the needs of their children who have been exposed to violence. After eliciting their perceptions, it is then important to ask that same question to professionals who care for families with children who are witnessing violence at home or in their neighborhoods and communities. Finally, since adolescents can speak for themselves, it seems logical to ask them about their own needs.

THE SETTING FOR THE PROJECT AND PRELIMINARY WORK

Haverhill, Massachusetts, a city of approximately 60,000, is located in the Merrimack Valley, northwest of Boston. During the decade of the 1990s, it was the third fastest growing city in Massachusetts, increasing 15% in population. Almost half the population is between 15 and 44 years of age (49.3%). Part of the population growth is individuals and families whose first language is not English. For example, more than 10% of elementary school students speak Spanish as their first language. The city has residents from the Dominican Republic, Cuba, Albania, China, Cambodia, Vietnam, Greece, Portugal, the Middle East, and most recently from Afghanistan, Pakistan, and Uganda (US Census Bureau, 2009). Many of the families emigrated for political reasons and have experienced trauma and loss.

In 1999, in the city of Haverhill, Massachusetts, a group of health care, social service, and law enforcement professionals formed a coalition to address violence in the community and named it the Haverhill Community Violence Coalition (HCVC). The original collaborators included representatives from the local hospital, the police department, the women's resource center, the regional visiting nurse association, the schools, and nurse practitioner faculty members from two universities. Soon this coalition expanded to include representatives from more than 30 agencies and institutions (Hawkins et al., 2008). The coalition members set priorities, including creating a CWV program in the community. A CWV program is available in an adjacent city, but there is no public transportation to and from Haverhill. After completing two pilot CWV programs, sponsoring training programs for HCVC members from the collaborating agencies, and studying the literature, we realized that little data exist to explicate the needs of children and adolescents who witness violence from the viewpoint of care providers, parents, and CWV. We identified focus groups as an appropriate method through which to elicit the information we were seeking.

FOCUS GROUPS: THE LITERATURE

Researchers from a wide range of disciplines use focus groups in particular to "give a voice to marginalized groups" (Morgan, 1996, p. 133). Women and children who are victims of domestic violence continue to be marginalized in societies around the world (Sokoloff, 2005). We sought to include multicultural constituencies in our investigation of the needs of children and adolescents who are witnesses to violence. Thus, focus groups are consonant with the oral tradition of many of participants (Ruppenthal, Tuck, & Gagnon, 2005). Kitzinger (1994) pointed out the importance of interactions among the research participants and argued that researchers must explore and exploit such interactions as part of the research process.

To promote interactions, we chose groups to participate whose members knew one another. Congruent with the literature on focus groups, we prepared questions that would allow participants to reflect on their own experiences and expertise on the subject of child witness to violence (Ruff, Alexander, & McKie, 2005). Ginsburg and colleagues (2002) encouraged learning directly from adolescents through focus groups, so we planned to conduct one focus group comprised solely of adolescents. Following the recommendation of Hollander (2004), we planned groups that were homogenous in order to minimize issues of status and power, including disclosure of abuse or that their children were witnessing incidents of interpersonal violence. Thus, we planned five focus groups, each comprised of individuals with the same or similar characteristics (Morrison-Beedy, Cote-Arsenault, & Feinstein, 2001): adolescents, Department of Social Services staff, members of the HCVC, women survivors of domestic violence who are also mothers of children who have witnessed violence, and Head Start mothers and staff members, noting that Head Start parents have an integral role in Head Start programs and often segue to roles as staff members.

THE PARTICIPANTS

To elicit information on the needs of children and adolescents witnessing violence in their homes, neighborhoods, or communities, we held focus groups with parents/mothers who are survivors of IPV and whose children are CWV, care professionals who work with families touched by violence, and adolescents who had witnessed violence. The total sample size was 45 participants. The aim of the focus groups was to elicit information about interventions that the participants believe might be helpful for the children, adolescents, and their families. By asking mothers what services they believe they and their children need, providers of care can design services that will better meet the multiple needs of these families. Adolescents are able to articulate their own needs, so we held a focus group with teens at Haverhill High School. Other focus group participants included care providers at the local Department of Social Services (DSS) office and HCVC members, who represent a wide spectrum of care providers.

PROCEDURES

After receiving approval from the Boston College Institutional Review Board (IRB), we recruited a purposive sample of participants for the project group through flyers and personal contacts who were members of HCVC. The IRB, as well as the agencies through which we solicited participants, requested that we not audiotape the focus groups, but rather designate a scribe. We limited the size of the focus groups using guidelines from the literature (Cote-Arsenault & Morrison-Beedy, 1999). Prior to beginning each focus group, we elicited written consent from each participant. Two investigators attended each focus group, one to serve as moderator and one to serve as scribe. The scribe is an active member of the research team and could ask for clarification from a focus group member during the focus group or after its conclusion. We held five focus groups, one each with Department of Social Services (DSS) staff, members of the HCVC, a group of women who are survivors of DV and mothers of children who have witnessed violence, staff members and parents at Head Start, and teen members of the Violence Intervention Prevention (VIP) group at Haverhill High School. We chose sites and times that offered privacy and were convenient for the participants. Each focus group only met once and we continued each focus group until participants didn't have any more they wanted to share about the topics being discussed.

We began each focus group with a brief overview of its purpose and with the same scenario, modified as appropriate to reflect the composition of the group. This scenario is as follows:

> For purposes of this discussion, let's assume that DSS has been given a $500,000 grant to be spent solely on services to reduce the effects of witnessing violence on children and teens in the Haverhill community. How would you spend this allocated money? What new programs would you initiate?

For the teens, since they are child witnesses to violence in addition to possibly caring for siblings and friends who are CWV, we added questions that we felt were age-appropriate. One query will suffice to illustrate: Please describe violence you may have seen, been part of, or heard about from a friend that happened within your community, school, neighborhood, or at home. How does it make you feel when you think about it?

After each focus group, the leaders held a debriefing session (Traulsen, Almarsdottir, & Bjornsdottir, 2004). The scribe prepared the notes as soon as possible so members of the research team could review them before conducting the next focus group.

DATA ANALYSIS

Data consist of notes taken by the scribe of the focus group members' discussions. Consonant with recommendations from the research literature, we analyzed the data using content analysis, reading the data line by line, noting themes and preserving salient quotes (Ginsberg et al., 2002; Hsieh & Shannon, 2005; Morrison-Beedy et al., 2001; Ruff et al., 2005). Themes were then verified with the field notes. For each focus group, the moderator and the scribe collaborated on analysis, including comments on the verbal and non-verbal contributions of members of each focus group.

RESULTS

Voices of the Mothers

Six women, all of whom are mothers and DV survivors, participated in this focus group, held in a church in Haverhill, where these women meet weekly in a support group for survivors of DV. These women, whose children are CWV, emphasized the importance of programs designed for all ages of children who have been witnesses to violence. They suggested that the ideal

would be to have school-based programs targeted at all grade levels. The women also discussed the need for individual therapy for some children.

One woman mentioned that her child was intimidated and fearful, at first, of being alone with the therapist and expressed worries about her mother. Several other women in discussion agreed that their children prefer group sessions so they will not feel alone in their fears and worries about their mothers. For example, one woman suggested that "someone cool" (of high school age) might be a good leader especially if that person had also experienced abuse. Having someone talk to kids who has been through violence in his or her own home might be better able to understand the concerns of CWV than a leader who had no personal experience with violence. Several women discussed the difficulty in reaching their teenagers, their inability as mothers to make the teens go for help, and their observation of the teens numbing their pain with alcohol, drugs, or food. The mothers all spoke of the need for children to be taught in school about domestic violence at a very early age, and taught appropriate behavior, stress management skills, and how to treat one another, as in co-creating "the peaceable classroom."

All the women agreed that better services for them, as mothers, would help their kids. They noted a lack of advocates for women, strongly endorsed support groups for women such as the one they attend weekly, and suggested that groups designed for kids should meet at the same time as the women's support groups. Furthermore, creating healing activities for women such as karate, yoga, and meditation would help ameliorate some of their stress through mind-body mechanisms known to be effective at helping with decreasing autonomic nervous system activation. It is possible that with time, women's and children's needs for healing could be partially met through stress-reducing mind-body activity groups. In planning interventions, parents and schools should be partners in crisis centers and after school programs. As a healing intervention strategy, survivors of DV could talk with teens, but teens also need to hear from their peers who have lived with DV. Based on the focus groups' discussion, a multifaceted approach is called for.

Another area of critical importance is education of counselors, teachers, police, lawyers, and judges, as these women perceived indifference, instead of advocacy. These women felt strongly that the court system was not helpful for them and their children. For example, as several women pointed out in discussion, the men who are the perpetrators of the violence often "have more presence and are very clever" in court as well as in their interactions with police, lawyers, and the judges. As a result, the women are left financially with nothing. The women noted how hard it is on the kids. For example, "father bashes the mother but it hurts the kids!" or, the issue of "how fathers buy kids stuff . . .", "the Disney Dad . . . everything the kids want." As this is a salient issue for some of the women, several emphasized the need for education of the guardians ad litum who supervise visits of children with their father.

Another priority of these women is the guilt they feel—"terrible guilt about taking it [abuse]," and the women worry about others knowing too much "feeling like everyone can figure it out—what happened to me." They also experience guilt from their kids: "Why did you put up with that?" To help their children, the women recommended being open, letting them know how much it hurts, and admitting mistakes.

Voices of the Adolescents

The 14 adolescents in the focus group were particularly articulate in discussions about their concerns and needs. Several spoke about violence in society, in movies, and the need for restrictions on violence in the media and on video games. The teens commented on the lack of a loving father figure and the role of men in the media. Several discussed ambivalent feelings toward their fathers and noted that men in the media are often portrayed as "tough." To illustrate the pervasiveness of violence and the types of violence the teens are exposed to outside the home, one participant talked about a kid who died in a fight trying to defend someone else. Anger was a difficult emotion that the teens talked about in relation to the violence: "I grew up as an angry kid in poverty—mom can't help as she is working two to three jobs, my stepdad puts her down and I am in the middle . . . you rely on your friends who are like family—all you see is violence in your own family." Several teens alluded to the importance of finding self and balance—"don't listen to family, follow your own dreams, find a balance—family/friends versus your own will."

Respect was very important to the adolescents who had witnessed violence; thus, it is critical that respect, not fear or humiliation, be the value undergirding helpful interactions. Also important to the teens was having interactions with adults who have "been there," too. They wanted teachers and counselors who could respectfully empower them versus focusing on their teacher power. For example, "teachers with power bring the student down." Furthermore, the adolescents perceived the importance of talking with guidance counselors about interactions based in respect versus anger. Helpful interactions with adolescents who have witnessed violence need to be grounded in respect and sensitivity to their needs as well as a grasp of their lifeworld. That is, it appeared to be important to meet the teens where they were and to help them clarify their feelings by listening to their stories of trauma and survival. Respect and sensitivity to aspects of their lifeworld can serve as a basis for teens' self-empowerment and for facilitating healing of injuries that aren't merely physical.

The teens' specific recommendations for kids who witness violence included: peer-on-peer groups for kids who have experienced the same situation, creating feelings of respect, welcome, and comfortableness in a group, and program leaders who have been through their own experiences. The adolescents also discussed needing support to bring their academic grades up, manage emotions "when anger boils up," and cope effectively with

jealousy in relationships. They talked about the need for a place to go and talk, and adults who give kids their undivided attention. They identified needs for both individual and group CWV programs designed for teens, including training in techniques to deal with stress and anger, and different types of activities to aid healthy coping. Several adolescents said physical outlets, such as rapping, dance, drawing, and music, help keep them out of trouble. For example, one adolescent emphasized that kids who witnessed violence need a toolbox to decrease their stress—such as dance, cooking, and/or a whoopee cushion. The adolescents also identified awareness of violence, its myriad consequences, and ways of transcending its negative influences as an important aspect of any program. Several commented that "the role of the Violence Intervention Program (VIP) at the local high school is to raise awareness with kids." One teen observed that kids "may have to go through life changing experiences to get a wake-up call."

Role modeling was discussed as being especially important to these teens. Participants were very vocal about their need for good role models and honest adults in their lives, such as "a guidance counselor who is straight and honest with you." Several commented on the lack of good role models, specifically in their own fathers or stepfathers. One teen explained: "Pay attention to the role models who are there; you need a constant role model always there; some people don't have that—many more bad ones than good ones . . . keep looking for the good ones." In differentiating a good role model from a bad one, a participant emphasized, "A good role model will tell you not to do something."

Voices of the DSS Staff

Nine staff members of the local office of the Massachusetts Department of Social Services (DSS) participated in the focus group. They noted the presence of children and adolescents in their caseloads who are CWV, some whose mother's abusers are still in the homes, noting that those children need CWV services, too. One key point related to interventions emerging from the focus group is the need for population-specific programs in languages other than English. The Haverhill community is multicultural so careful consideration of different needs based on language and cultural issues is needed.

The DSS staff participants stressed the need for school-based prevention programs focused on bullying and types of interpersonal violence (IPV), programs for kids whose abuser is their mother, and intervention programs for mothers who are abused, as well as intervention programs for abusers. In relation to abusers, they discussed a need for short-term (6–12 weeks) batterers' programs that would nip violence in the bud when it starts occurring in a relationship. Several participants talked about the importance of male mentorship and role modeling of healthy relationships, possibly in church communities. They highlighted the need for mentorship programs for single mothers that would address their dependency needs, such as tolerating abusive partners for financial reasons. Others expanded on this idea, suggesting that healthy survivors might provide mentoring for newly battered women. Included as important in this mentoring would be helping women understand specific legal matters like "no abuse orders" versus "full restraining orders," teaching women how to develop safe behaviors and relationships, and closely examining what factors contributed to them actually getting to the "battering stage" in relationships. The participants also discussed a need for services to help children cope with the loss of the batterer from their lives, as well as other issues they experience as a result of DV, such as decreased self-esteem and getting into abusive relationships themselves.

In line with empowering women to be safe, one participant noted the "girl power program" in Haverhill. In that program, the leaders give girls and women hints about hair, make-up, music, and dance, but the clear message is that girls and women need to feel empowered. Another participant suggested art therapy as a healing modality because she believes that women are repressing the cause of their distress. The DSS staff articulated the need for after school programs for CWV, a teen drop-in center in the community, and theatre groups, so kids can express what they are enduring in music, art, dance, martial arts, and sports.

Voices of the Head Start Parents and Staff Members

Seven Head Start parents and staff members participated in the focus group held at one of the Haverhill Head Start facilities. Several participants cited the high school Violence Intervention Program (VIP) activities and performances that address community and domestic violence. In particular, they mentioned "Yellow Dress," a one-woman play based on stories of young women who were victims of dating violence, which was followed by a discussion about relationships (Deana's Educational Theatre, 2007). Several participants spoke of a critical need for education for advocates—teachers and family who conduct face-to-face visits with kids and often see CWV and child abuse. One staff member noted that programs for preschoolers are important if the abuser is out of the home.

The Head Start mothers and staff agreed that Head Start teachers and advocates need training to identify cues for CWV. They suggested that Head Start staff could help families when doing pre-visits for Head Start. In relation to this point, for example, a mother participating in the focus group noted that it is helpful to recognize that her son is emulating the behavior of his abusing dad.

The mothers and staff discussed a need for summer programming for preschoolers, sports activities as a therapeutic outlet, and the need for members of neighborhoods to be involved in programming for kids. Within this line of discussion, a staff member and a mother praised a camp program and a horse back riding program for kids who are CWV. Several participants had accolades for a pilot CWV program that was implemented at Head Start and wished for continuation of the program. One

mother noted the need for individual therapy for mothers and kids, with separate therapists. For example, one mother spoke of her need for skills in talking and assertiveness training. A staff member noted that parents need training about what to do with their kids and alternatives to violence. In response, a Head Start staff member noted that the agency does offer counseling and support. Furthermore, staff discussed the need for expert training on DV, CWV, and how to respond appropriately and safely, noting that some batterers are still in the homes and often bring kids to Head Start. Staff members also noted the need for teachers to validate the anger that children have as a result of CWV.

Voices of HCVC Members

Nine members of the HCVC, representing a variety of disciplines and agencies, articulated a need for training on CWV for school staff, DSS workers, judges, teachers, probation officers, day care providers, Head Start staff, school bus drivers, and essentially all folks who work with kids. Types of services and venues for services include outpatient; during- and after-school programs; drop-in, lunch, and round table groups; camp programs; and Big Brother and Big Sister programs. The participants noted that teens, especially, need anger management skills. Participants alluded to the need for different media to reach kids of different ages. They emphasized that kids need safe places to meet and congregate, and programs that are run during the school day.

The HCVC participants identified a number of barriers to accessing CWV programs, including transportation, babysitting for other children, lack of programs for grammar and high school kids, rules that can put teens off, leaders whose only knowledge of violence is through books, and the requirement that the batterer no longer reside in the home. They noted that probation officers and teachers need both awareness of the problem of CWV and sensitivity training. Participants noted a wide range of individuals with whom kids come in contact and the need to educate these persons (school bus drivers, day care providers, school and head Start staff) about the problem of CWV and how it affects kids.

THEMES AND RECOMMENDATIONS EMERGING ACROSS FOCUS GROUPS

Youth who are witnesses to violence in their homes or communities live in challenging environments. As Ginsberg and colleagues (2002) learned through focus groups with inner city youth in Philadelphia, priorities for the kids are "solutions that would promote educational or job opportunities" (p. 1). This finding is not unlike what we learned from our focus groups. The mothers and adolescents are looking for help through mentors, for opportunities to rebuild their lives free of violence, and for encouragement in their goal to support themselves and their children. But, women and children living with their abuser in the home have unique needs for services. Changes in the court system are necessary to make it more sensitive to the needs of women and their children, and to neutralize the power that abusers and their lawyers hold. More legal advocates for victims of abuse would be helpful to women. Suggestions for assisting families with CWV include outreach from hospital emergency room staff who can present the ramifications of violence, and an automatic referral process for when officers make a domestic violence call where children are present and when a restraining order is filed. Recommendations for programming, stemming from our focus group discussions include:

- peer-to-peer support education in the school system to help teachers and counselors learn to be aware of the signs of violence occurring in a child's home and ways to help
- support in the schools for the children and teachers
- programs to provide male and female mentors, support persons, and role models
- help for children to see that they have a choice in how they live their lives, and that they can choose nonviolence
- supportive persons who will be honest and respectful
- involvement of the wider community in violence programs, such as health care providers, legal advocates, social workers, clergy, politicians, government, leaders, teachers, parents, kids, schools, daycare providers, Head Start staff, bus drivers, etc.
- basic needs, such as transportation and child care, so CWV and their mothers can reach and access available services
- programs for kids who have a parent incarcerated because of DV
- anger management and conflict resolution programs for teens
- outreach to children of all ages, to catch them "before it's too late"
- stress reduction and fun activities: drawing, dance, camp programs, rap/music, karate, yoga, art, meditation
- outreach from hospital emergency room staff to present the ramifications of violence to community members across the age continuum
- automatic referrals when officers make a domestic violence call and children are present in the home and when a restraining order is filed

LIMITATIONS

The findings of this study were interpreted from participants living in the northeastern region of Massachusetts and may not correspond to experiences of people living in other regions of Massachusetts or elsewhere. Participants self-selected, consistent with purposive sampling for focus groups, but inherent within this approach is self-selection bias. Also, input from young children could have been obtained through observation

and play activities, and would have strengthened the findings further.

IMPLICATIONS FOR FURTHER RESEARCH

Further research to explore the experiences and facilitators of healthy development for children who witness violence is important given the findings of this study. Understanding the lived experiences and social, academic, and emotional development of children who witness violence is an area of inquiry in need of further research and theoretical development. Many opportunities exist to develop relaxation and fun exercises and school- or community-based violence education programs as interventions. These can be tested to see if they ameliorate some of the stress children who witness violence experience. From a research perspective, information is needed related to the effect of mind-body relaxation interventions and fun on children's perceptions of meaning related to violence experiences, overall health promotion behaviors, quality of life, and well-being. Furthermore, barriers that providers face in developing and implementing programs for children who witness violence need to be identified so that systemic changes can be planned. Research to compare intervention programs that include different combinations of group work for children (with and without parent groups as a component) would help to discern the contribution of different approaches to overall child emotional, behavioral, and cognitive outcomes. For children and mothers who witness or experience violence and develop posttraumatic stress symptoms, empirically-supported trauma-focused interventions such as Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro & Forrest, 1997) and Child-Parent Psychotherapy (CPP) (Lieberman, Van Horn, & Ippen, 2005) could be evaluated for efficacy.

CONCLUSION

Based on the findings of this research, a basis for programming and further study is clear. Participants noted that kids who witness violence need programs that begin in preschool or elementary school and progress with the ages of the children to help them heal, build resilience and conflict resolution skills, and acquire skills to deal with upsets in their lives. Several noted the importance of the VIP program in the high school and the need to have this program in the elementary and middle schools. Most of all, kids need to hear that DV is not their fault, that it is not okay, and that there are positive outlets available for them through the schools and in the community. They need to be engaged in creative and healthy avenues for self-expression, healthy identity, and stress management as well as experience humanistic caring environments and relationships that bolster their healing.

Screening for abuse at each health care encounter takes on new meaning and urgency in the context of the threat of homicide (Campbell et al., 2003) and the monetary (National Center for Injury Prevention and Control, 2003) and human costs of abuse for society and the victims.

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