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Childern Witnessing Domestic Violence

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SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING

MASTER'S PROGRAM PROJECT OPTION (PLAN B)
PROJECT SIGNATURE FORM

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TITLE OF PROJECT: CHILDREN WITNESSING DOMESTIC VIOLENCE

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

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DATE

Please submit this form to the Graduate Coordinator. Attach the abstract, two copies of the manuscript, and documentation of submission to the journal.

SAN JOSE STATE UNIVERSITY
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PROJECT ADVISOR APPLICATION

Prepare a short paper (3-5 double spaced pages) which addresses each of the following. Turn it in to the Graduate Coordinator by May 10 or December 10 of the semester before implementation of the project.

1. Succinct statement of problem and significance of the problem (1-2 pages);

2. Category of project, (A-G on Plan B information sheet) e.g., implementing and evaluating a health program or completion of a needs assessment;

3. Purpose statement (one sentence);

4. Detailed description of the project including each of the following, if relevant.

   a. subjects or clients;
   b. test materials, questionnaires, surveys, or other materials to be used (attach a copy of each);
   c. the intervention, implementation, or what the subjects or clients will be required to do;
   d. data collection procedures;
   e. procedures to protect subjects confidentiality;
   f. data analysis procedures.

5. Agency permission letter, if relevant.

6. Title and format guidelines for authors from the professional journal for which your manuscript will be written.

Abstract

Statement of Problem: Although witnessing violence in the family may account for many symptoms brought to the attention of the primary care providers, such violence is seldom identified as an issue. The purpose of this study was to assess the incidence of children witnessing violence in the home, as self reported by victims of domestic violence in a clinical setting.

Method: The study was a retrospective chart review. Data was gathered from a survey administered to individuals identified in the emergency department as victims of domestic violence. The survey addressed demographics, child witnesses to violence, and co-factors of violence including child abuse, alcohol use and weapons in the home.

Results: Out of the 120 participants, the highest proportion was categorized as single/divorced. This study found that 75% of the children witnessed domestic violence in the home, as self-reported by victims of domestic violence. The mean age of the children was 8.4 years. The incidence of concurrent child abuse was 19%. The victims of domestic violence self-reported a much higher rate of alcohol use by the perpetrator as compared to their own alcohol use.

Conclusion: The findings indicate that children as witnesses to domestic violence is alarmingly high. Universal screening by health care providers ensures that not only are adult victims identified, but also the needs of the children are not overlooked. It is mandatory to identify children living in violent homes so their emotional and physical health can be preserved at the earliest developmental age possible.

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Children Witnessing Domestic Violence

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Children Witnessing Domestic Violence

Domestic Violence (DV) and spouse abuse are terms applied to violence occurring between partners in an ongoing relationship whether or not the partners are married (Peled, Jaffe, & Edleson, 1995). Estimates on individuals experiencing interfamilial violence vary depending upon the definition, circumstances, and method of inquiry. Studies suggest that as many as four million women are physically battered each year by partners, including husbands, ex-husbands, and boyfriends (Peled et al., 1995). Battered women have been studied throughout the ages. Until recently, the needs of children who witness family violence in their home have largely been overlooked.

Children as witnesses to domestic violence are considered silent victims. It has been documented that children who witness domestic violence suffer long term emotional, behavioral, and physical problems. Approximately 3.3 million children in the United States (US) between the ages of 3 and 17 are "at risk" of exposure to parental violence each year (Peled et al., 1995). This estimate is based on the reported incidence of domestic violence. Wolfe and Korsch (1994), stated "Researchers now suspect that children who witness DV may widely outnumber victims of physical abuse" (p. 594).

Given the magnitude of violence in our society, it is vital for primary care providers (PCP) to recognize the need for early detection of family violence. Primary care providers render care to entire families and need to understand that poor health and emotional outcomes occur in families who experience domestic violence. The cycle of violence is perpetuated when health professionals do not recognize or acknowledge that family violence may exist. Primary care providers need to address family violence directly, by

identifying victims of violence, and effectively treating the patient's emotional and physical health needs. Early detection and intervention by health care providers may reduce morbidity and mortality that results from further violence either to the victim or their children.

Literature Review

There has been a recent increase in literature dealing with children witnessing family violence and the subsequent behavioral problems at home, school, and in the community. Researchers have attempted to document the correlation between witnessing domestic violence and subsequent child and adult maladaptive behaviors (Cappell & Heiner, 1990; Davies & Flannery, 1998; Fantuzzo & Linquist, 1989; Felitti et al., 1998; Fergusson & Horwood, 1998; Kilpatrick & Williams, 1998).

In determining the effects that witnessing domestic violence can have on children, information is needed on their actual exposure and perceptions about family violence. Family violence manifests itself in many forms, making it difficult to isolate any single factor that negatively impacts the children witnessing the violence. The factors that may influence the impact that violence has on children include: age, gender, developmental phase of the child, frequency and type of violence, support provided by caregivers, previous experience of trauma, child perception and coping skills, and proximity to the violent event (Knapp, 1998).

Long term implications

Research also suggests that children exposed to domestic violence have a greater incidence of adjustment disorders in a number of areas including health, behavioral

problems, and disorders in cognitive and emotional development (Hall & Lynch, 1998). The impact of children witnessing domestic violence appears to manifest itself in various ways in adulthood. The long term effects include: self-harm, eating disorders, Post Traumatic Stress Disorder (PTSD), violence, educational failure, anxiety, social isolation, conduct disorder, crime, and problems with alcohol (Fergusson & Horwood, 1998).

Post Traumatic Stress Disorder exists in children who witness domestic violence according to Kilpatrick and Williams (1998). However, no single factor, such as age and gender of child, maternal emotional well being or the child's style of coping with parental conflict could be identified that influenced the severity of PTSD experienced by children.

The interrelationship between childhood exposure to abuse and household dysfunction and long-term health consequences were examined by Felitti et al. (1998). Their findings revealed a strong relationship between exposure to abuse during childhood and multiple risk factors for several of the leading causes of death in adults. These risk factors exhibited by the exposed children included alcoholism, depression, suicide attempts, cancer, chronic lung disease, and liver disease.

Cappell and Heiner (1990) studied the intergenerational transmission of violence. They suggest that men and women who experienced or witnessed aggression in their families of origin learned or socially inherited vulnerability (Cappell & Heiner, 1990). This vulnerability is described as: "Learning to provoke violence; learning to tolerate violence; learning to select aggressive partners for marriage; or failing to inherit the psychological, social, and material resources sufficient to escape being vulnerable" (p. 146).

Impact on children

Lieberman and Van Horn (1998) conducted a qualitative study that looked at mothers' interactions with their 3-6 year old children (who had witnessed DV). The findings revealed several common themes in the children such as: (a) PTSD reaction, (b) helplessness, (c) longing for absent father, (d) identification with the aggressor, and (e) fear, protectiveness, and anger of the mother.

The psychosocial and developmental effects on children witnessing domestic violence were also reported by Knapp (1998). The author reviewed information on the high incidence of children witnessing violence in various settings and suggested intervention strategies and the need for appropriate referrals for children who witness violence. Knapp (1998) identifies physicians as particularly responsible for recognizing a child's emotional pain and providing or recommending effective treatment.

Berman (1999) studied the parallel experiences of violence among children of battered women and refugee children of war. A convenience sample of 16 refugee children of war and 16 children of battered women were studied in 1995-1996. Findings of the study revealed that both groups of children experienced pain, suffering, and feelings of betrayal. Although the children's initial background experiences were different, both groups used similar coping strategies to survive. An important finding of the study was that the children in both groups wanted to share their experiences of the violence they witnessed.

Children as witnesses of violence: Incidence and alcohol use

Richters and Martinez (1993) conducted a study of Washington, D.C. school children and their parents. The study sample included 165 children, aged 6 to 10 years, and their parents. Nineteen percent of the younger children had been victimized, but 61% had witnessed violence toward someone else. Among the older children, 32% had been victimized, while 72% reported witnessing violence. Findings showed that young children are frequently involved in violent events and that discrepancies exist between the parents' report of violence when compared to their children's report of the violence witnessed. The children usually reported higher incidences of violence exposure.

Jaffe, Wolfe, and Wilson (1990) also supported the above findings. They concluded that even when parents believe domestic violence went unnoticed, children can often give detailed reports about violence in their home. In addition, the children's perception of the violent event can be quite detailed.

Taylor, Zuckerman, and Harik (1994) administered a standardized questionnaire to 115 mothers of children from a pediatric primary clinic at Boston City Hospital. Ten percent of the children were reported to have witnessed a knifing or shooting, 18% had witnessed shoving, kicking, or punching, and 47% had heard gunshots. The results indicated that children had witnessed both significant and repeated violence.

Hutchison (1999) interviewed 419 women after a domestic assault and correlated data from police reports to assess whether children were present during the assault and whether the perpetrator used alcohol. The study revealed that a majority of women had at least one of their own children living in the home and that almost half of the violent attacks

had taken place in front of the children. In addition, the batterers consumed considerably more alcohol than the victims did at the time of the assault, regardless of children's presence.

Health professional attitudes

Medical practitioners' attitudes regarding the reporting of child abuse and neglect was studied by Haeringen, Dadds, and Armstrong (1998). They sent a survey to pediatricians at a training hospital asking them to respond to three case vignettes suggestive of possible physical abuse or neglect, and to report their own behavior related to suspected child abuse or neglect. In this study, 43% of the physicians declined to report child abuse despite a legal mandate to do so (Haeringen, Dadds & Armstrong, 1998).

In another study of primary care providers, 28 pediatric nurse practitioners were surveyed by Mahoney and Campbell (1998). They were asked to describe their thoughts or experiences from a developmental perspective of children who had witnessed domestic violence. The pediatric nurse practitioners identified extreme aggression and withdrawal as behaviors exhibited by children who witnessed domestic violence. These findings suggest that pediatric nurse practitioners can be instrumental in identifying children who are witnessing domestic violence.

The evidence suggests that children are witnessing violence at an alarming rate. However, primary care providers rarely screen for family violence. Wolf and Korsch (1994) agree that family violence is not adequately recognized by primary care providers. Thus, Wolfe and Korsch (1994) recommended guidelines regarding children witnessing domestic violence for pediatric practices. These recommendations included decreasing

attitudinal barriers to domestic violence, increasing sensitivity to clinical features and behavioral symptoms of children who witness domestic violence, and increasing awareness of available resources for treatment and prevention (Wolfe & Korsch, 1994).

Significance of This Study

Knapp (1998) states that over the last ten years Americans have realized that violence is an integral part of our lives and has the most profound effect on children. The literature reflects an awareness of the importance of studying particular aspects of child witnessed violence, especially the long-term health implications for the child exposed to these traumatic events. The literature regarding children and DV exposure is abundant with research about negative health consequences. The studies, for the most part, are concerned with various forms of violence such as media, gang, or community violence. DV exposure is intermingled into most studies of child violence, but not identified as an isolated factor. The literature review reflects that child witnesses to DV are reported as estimates based on women who are victims. Whereas, this study identifies specific incidences of children exposed to DV in the home, as identified by mothers in a clinical setting.

This study validates the importance of identifying child DV exposure during routine primary care visits. There exist a number of articles that pertain to primary care providers and the importance of documenting and intervening when DV is an issue. Berman (1999) concurs with our assessment of the literature, that not only should primary care providers view the women as victims but also their children. There must be early detection and intervention on behalf of the women and children victims of family violence.

Theoretical Perspective

This study uses the Roy Adaptation Model to explain how adaptation to family violence may be either effective or ineffective. Roy views the person as an adaptive system (Roy & Andrews, 1991). An individual receives a stimulus from the internal or external environment. Their coping mechanisms, either the cognator or the regulator, aid the individual in adapting to the stimuli. Since we are unable to observe the cognator and regulator subsystems, Roy and Andrews (1991) identify four categories or adaptive modes that can be assessed and observed. The four modes are: psychological; self-concept; role function; and interdependence (Roy & Andrews, 1991, pp. 15-17). These four modes are interrelated. A given stimuli can affect more than one mode, and a particular behavior can be considered adaptive in more than one mode.

The response of the person to DV can either be adaptive or ineffective. A positive response would be adaptation which would contribute to one's health and well being. An ineffective response does not contribute to adaptation and could be a serious threat to one's survival. However, Roy suggests very broad guidelines to evaluate what is adaptive and what is ineffective. The person's individual goals are taken into consideration when determining whether a response is adaptive or ineffective. Ineffective responses in the eyes of one may be considered adaptive for another.

The Roy adaptation model can also be used to guide the treatment of a victim of domestic violence. A victim of domestic violence requires both medical and psychological attention. According to Roy, the coping mechanisms a victim uses are related to the cognator and regulator. The four adaptive modes are used in assessing the victim of

domestic violence. The physiological mode includes all of the physical trauma the victim received during the assault. The self-concept mode focuses on the psychological and spiritual aspect of the victims, including mother and children. The self-concept for the victims of domestic violence is challenged. They often have difficulty with a lack of self-esteem. The model points out that this is a very difficult situation because it can interfere with what the victim must do to maintain health or deal with the situation (Roy & Andrews, 1991).

The role function mode is also very difficult for the victim. The victim can be placed in many different roles that can be confusing. The victim may re-evaluate their role after the violence. The role function responses can be identified as: lack of interest in activities, problems with children, occupational problems, educational problems, economic problems, and social problems. The interdependence mode can be the most difficult area for the victim of domestic violence. The victim may not be ready to discuss domestic violence or be able to provide information. Responses that a victim might have related to the interdependence mode can be problems with living arrangements and problems with primary support. The response of the significant other and the support system can also be very crucial to the adaptation of the victim.

The adaptation model may explain why a victim has difficulty identifying herself and her children as victims in need of help regarding resources and health referrals. Different individuals may have similar focal stimuli. However, the contextual stimuli for each individual may be unknown. Consequently, it is difficult to determine each individual's level of adaptation and their reason for not seeking initial health resources,

counseling information, and referrals. For example, the victim may perceive that the bruises and lacerations are healed. Yet, the victim may not recognize the long-term health implications for herself or her children when living in a violent relationship. That is why assessment of the additional contextual factors, including children witnessing abuse, need to be evaluated in order for health care providers to assist families in finding the appropriate adaptive response.

Method

This study was a retrospective chart review. Materials reviewed in the medical records were the VIP documentation form and the Suspected Violent Injury report for Santa Clara County. The forms incorporate yes/no type answers and ask if children in the home witnessed DV. The forms also included demographic data. Data collection took place from September 1998 through March 1999. A total of 166 medical records of victims of domestic violence patients were reviewed. A total of 46 patients charts were excluded from the study. The reasons for exclusion were either for non-domestic violence assaults or because the patient declined to be interviewed by the VIP team. Of the 120 victims included in the data, 7 were men.

The subjects for the study were patients identified as victims of DV and referred to the VIP team at Santa Clara Valley Medical Center. The VIP team consists of an advocate from Next Door Solutions to Domestic Violence and a forensic nurse. The forensic nurse is responsible for interviewing, evaluation, documenting, and photographing any injuries. The documentation includes both a detailed account of recent and past abuse, and the reporting requirements for local law enforcement agencies.

The charts of the patients seen by the VIP team at Santa Clara Valley Medical Center were reviewed by the researchers to obtain the data concerning domestic violence and children witnessing violence in the home. The measure of children present was based on the question asked of the victim: "Have children witnessed violence in the home?" Victims were asked about their own and their partners' alcohol and substance use.

Results

Sample Profile

Of the 120 patient's whose charts were included in the study, 51 (42.5%) were single and/or divorced. Thirty-six (30%) were married, 30 (25%) were co-habitating, and 3 (<1%) were married but separated. Racial and ethnic background was divided into 5 categories: Hispanic 46 (38%), White 42 (35%), Asian 13 (11%), African American 10 (8%), and other mixed background 9 (8%). The ages of the participants were categorized as follows: 4 subjects (3%) were under age 18 years, 22 subjects (22%) were between 18 and 25 years, 33 subjects (27.5%) were between 26 and 35 years, 41 subjects (34%) were between 36 and 45 years, and 16 subjects (13%) were over 46 years. The mean age of the victims was 34.4 years with a range of 16-65.

Children Present

Sixty-eight (57%) participants, including 4 men identified as victims of domestic violence had families with children living in the home. The 68 participants had a total of 142 children currently living in the home. Data on children's ages were categorized as follows: infants (ages 0-1), preschool (ages 2-5), school age (ages 6-11) and adolescents (ages 12-18). The infants represented 14 (10%), preschool 42 (30%), school age 42 (30%)

and adolescents 44 (31%) of the total number of children living in a home where domestic violence was identified. The mean age of the children was 8.2 years with a range of 1 month to 18 years of age.

Out of the 68 families with children living in the home, 51 (75%) of the victims of DV reported that children witnessed violence in the home. There were 17 (25%) victims who reported that their children did not witness the violence. In addition, 13 (19%) out of 68 victims with children, reported that their children were also victims of abuse by the abuser.

Of the 68 families, the average duration of physical abuse was 4 (3.98) years with a range of 1 month to 27.5 years. The average duration of emotional abuse was 4 (3.69) years with a range of no reported emotional abuse to 27.5 years.

Alcohol and Drugs

Forty-five (66%) of the 68 victims with families self-reported that drugs and alcohol were used by either the victim or the abuser. Furthermore, victims without children reported that drugs and alcohol were used by either the victim or abuser in 39 (75%) out of 52 cases. In families with children identified as witnesses to violence, 33 (65%) out of 51 self-identified drugs and alcohol as a cofactor. In 8 (62%) out of the 13 participants who identified that their children were being abused, drugs/ alcohol was self-reported as a cofactor in the abuse.

Miscellaneous

Weapons were reported to be in the home of 29 (24%) out of the 120 victims. The weapons reported included 15 guns and 14 knives. Nineteen (16%) out of the 120 victims were seen in the Emergency Psychiatric Services department. Seven (6%) of the 120 victims were pregnant.

Discussion

The researchers found that a high percentage (42.5%) of women considered themselves single. For health providers this points out an important issue. Women who are categorized as single are potentially at risk for domestic violence and need to be screened with the same intensity as women who are married or cohabiting.

The racial breakdown in the sample profile for those women who reported domestic violence compared to the racial/ethnic population in Santa Clara County showed considerable differences. The discrepancies were most noticeable in the Asian and African American ethnic groups. The Asian population in Santa Clara County is 22.5% (Santa Clara County, 1998). This number is much higher when compared to the Asian population of this sample (11%). This may represent underreporting by the Asian population. According to Salber and Taliaferro (1995), African American women are more likely to report and seek medical treatment for domestic violence. It is interesting to note that this study validates and supports the above premise. African American women were over-represented when compared to the county's African American female population by 5%.

The data from this study and the literature reflect that children are witnessing violence in the home at a disturbing rate. Victims were asked to self-report whether or not

their children witnessed violence in the home, and these statistics indicated that 75% of the children in families had witnessed family violence. This is higher than a study by Hutchinson (1999) documenting 59.2% of children living in the home had seen "the fight" which led to calling the police. Hutchinson's (1999) study was based on a single violent incident report whereas this study reflects a history of children witnessing violence. Jaffe, Wolfe, and Wilson (1990) reported that parents frequently denied that children were present during abusive incidents. In contrast, this study found that three-quarters of the victims self-reported that their children witnessed the violence.

When looking at the children's ages in this study, the various age groups were represented fairly equally except for 0-1 years. As cited earlier, the mean age of the children was 8.4 years, which represents a critical developmental period for children. During this phase, self-esteem and confidence are being developed. Wolfe and Korsch (1994) suggest that how children respond to family violence may be influence by gender. "Boys from violent homes were found in particular to be overly aggressive, non-compliant, and disruptive, and these symptoms often were quite noticeable and distressing" (p.596). On the other hand, girls, from violent homes will often display somatic complaints and negative internalizing behaviors. (Wolfe & Korsch, 1994). The emotional needs of children who witness violence in their homes also varies family to family.

Children in violent families are physically abused and neglected at a rate 15 times greater than the national average (Senate Judiciary Committee Hearing 101-939, as cited in Massachusetts coalition, 1995). This study found that 13 (19%) out of 68 families reported concurrent child abuse. However, there is evidence that child abuse is much higher in

domestic violent homes. Ross (1996) identified that there was a direct correlation between frequency of marital violence and child abuse. In families with 20-25 marital violent situations, the rate of concurrent child abuse was 50%. Ross' (1996) study was conducted at a battered woman's shelter. On the other hand, our data were gathered at a time when women were not in a position of relative safety, so their ability to be completely honest may have been compromised. The women may have felt the repercussions of reporting child abuse because they had not left their partner as yet. For these reasons the rate of marital violent situations and concurrent child abuse may be much higher than the numbers given by our participants.

Hutchison's study (1999) reported no significant difference in alcohol consumption whether or not children were present during the abuse. When comparing Hutchisons's (1999) results to our study, the findings were similar. Both Hutchison's (1999) study and this sample found that the victims' report of their alcohol consumption was significantly less than the abuser's.

Limitations of study

The researchers relied upon patients to give an accurate account of the violence and whether or not the children actually witnessed the violence. The accounts of the patients may not have reflected what the children were actually experiencing. A child who hears violence may not be considered a witness by their parents. The patients may not have been willing to disclose information pertaining to his/her children or the abuser. Also, women may fear the possibility of their children being taken away by child protective services.

The information given by the participants is second hand since the researchers were not directly interviewing the children.

Conclusion

To properly identify victims of domestic violence, it is essential to perform universal screening of clients for domestic violence in all clinical settings. Once a victim has been identified, it is extremely important to their and their children's future well being that they leave the clinical setting with some basic intervention having been made. This includes an assessment and discussion about domestic violence, safety planning, and appropriate referrals. In addition, it is fundamentally necessary to ensure that battered women and their children do not face roadblocks when attempting to keep their families safe. Women need to be reassured that when they disclose themselves as victims of domestic violence they are not also victimized by the system.

All health care practitioners must take an active role in identifying violence that children may be witnessing in their home. There is a need for greater awareness about family violence in communities and among health care practitioners who provide services for children. Children who witness family violence carry psychological scars, have long-term health consequences, and suffer failed human relationships (Cappell & Heiner, 1990; Davies & Flannery, 1998; Fantuzzo & Lindquist, 1989; Felitti et al., 1998; Fergusson & Horwood, 1998; Kilpatrick & Williams, 1998). However, children often have the ability to be resilient. It is important to identify children living in violent families so that these children have the best possible outcome at the earliest stage of development. Clinicians

must take responsibility for detecting family abuse, since not screening can be a form of denial or complicity. Children as silent victims need to be heard.

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