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Provider perceptions of safety planning with children impacted by intimate partner violence ☆

Evette Horton [a,*,1], Christine E. Murray [a], Bethany Garr [a], Lori Notestine [b], Paulina Flasch [a], Catherine Higgins Johnson [c]

[a] University of North Carolina at Greensboro, United States
[b] Adams State University, United States
[c] Family Services of Davidson County, United States

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ABSTRACT

Safety planning is a widespread intervention used with clients who have experienced domestic violence victimization. Although children are impacted by domestic violence, attention to the unique needs of children as they relate to domestic violence safety planning has received little attention to date. The authors conducted nine focus groups with domestic violence service providers about their perceptions of child safety planning. This article reports on the findings and implications of this focus group study that can inform the safety planning needs of children impacted by domestic violence. The themes discussed include Child Protective Services, the needs of older boys, school-related issues, custody-related issues, the extent to which children should be involved in safety planning, parenting issues, tools and tips for safety planning with children, and resources and services to promote children's safety.

1. Introduction

Intimate partner violence (IPV) describes physical, emotional, and/or sexual abuse between current or former intimate relationship partners (Murray & Graves, 2012). According to McDonald, Jouriles, Ramisetty-Mikler, Caetano, and Green (2006), 15.5 million U.S. children live in families in which IPV occurred at least one time in the past year, and seven million children live in families in which severe IPV occurred. The majority of IPV occurs within the home and children are often present in homes in which IPV occurs (Catalano, 2007). Because of these staggering figures, researchers have increasingly studied the impact of IPV on children and effective ways to address this impact, which includes child safety planning; however, it is unclear how child safety planning is being implemented in the field. The purpose of the current study was to conduct a series of nine focus groups with domestic violence service providers to learn about their perceptions and experiences related to safety planning with children exposed to IPV.

2. Literature review

2.1. Definition of child exposure to IPV

What does it mean for a child to be 'exposed' to IPV? Defining children's exposure to IPV is methodologically complex (Evans, Davies, & DiLillo, 2008). Certainly, some children see their parents or other adults (or older youth, in the case of teenage dating violence) experience IPV with their own eyes; however, children may also be exposed to IPV even, if they do not see it for themselves, such as if they can hear it from another room (Graham, Fischer, & Pfeifer, 2013) or if they observe the aftermath of IPV, such as an injured parent or destroyed property that resulted from it (Murray, 2013). Determining the extent of children's IPV exposure has practical implications, in that within many jurisdictions, children's exposure to IPV is reportable to Child Protective Services and may be considered *failure to protect* or *per se neglect* (Kaufman Kantor & Little, 2003; Murray, 2013). Therefore, professionals must be aware of necessary reporting requirements in their jurisdiction and understand specifically how witnessing or exposure to IPV is defined in those requirements.

2.2. Impact of IPV on children

Children who are impacted by IPV face numerous safety risks. As examples, they may be placed in harm's way during a violent incident between the adults involved in the IPV, they may be left with minimal or no supervision during violent incidents and/or as a result of a parent becoming incapacitated as a result of violent victimization, they may experience mental health symptoms (e.g., anxiety and traumatic stress) as a result of witnessing violence, or they may have access to weapons used during violent episodes. In addition, children who live in homes in which parental IPV occurs also face an increased risk of being victimized themselves through child maltreatment. Kaufman Kantor and Little (2003) report that rates of overlap between child maltreatment and

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* Corresponding author at: 221 Curry, Greensboro, NC 27402, United States. Tel.: +1 336 334 3426.
E-mail addresses: gehorton@uncg.edu, gehorton@email.unc.edu (E. Horton).
[1] Present address: UNC Horizons, 127 Kingston Drive Chapel Hill, NC 27516, United States. Tel.: +1 919 966 9803.

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parental IPV may be as high as 30% to 60%. Further, children exposed to IPV are at a higher risk of being exposed to other adverse experiences of household dysfunction, such as living with a family member with a history of mental illness, substance abuse, and/or imprisonment (Lamers-Winkelman, Willemen, & Visser, 2012).

Though the impact can vary by numerous factors, such as the duration and intensity of the IPV exposure and the development stage of the child victim, it is well documented that children and adolescents are affected by the IPV between their caregivers (Child Welfare Information Gateway, 2009). In general, the younger the age of the child, the more impacted the child is likely to be (Gjelsvik, Verhoek-Oftedahl, & Pearlman, 2003; Graham-Bermann & Perkins, 2010), and children under the age of six are at the greatest risk for exposure to IPV (Fantuzzo & Fusco, 2007). Graham-Bermann and Seng (2005) found that pre-schoolers who have been exposed to family violence suffer from symptoms of post-traumatic stress disorder, such as bed-wetting or nightmares, and are at greater risk than their peers of having health related symptoms such as allergies, asthma, gastrointestinal problems, headaches, and flu. Even infants have been found to have increased stress reactivity to interparental conflict (Graham et al., 2013). Researchers have also documented prenatal influences of IPV. Whitaker, Orzol, and Kahn (2006) found that children of mothers who experience prenatal physical IPV were at an increased risk of exhibiting aggressive, anxious, depressed or hyperactive behaviors.

Despite the evidence of the impact on younger children, all children and adolescents can be negatively impacted by exposure to caregiver IPV. Researchers found that child witnesses from ages birth to eighteen have greater internalizing behaviors, externalizing behaviors, and trauma symptoms, as compared to children not exposed to IPV (Evans et al., 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003).

2.3. Safety planning for children impacted by IPV

Safety planning is a widely-used intervention for victims of IPV, especially its most severe form of battering. According to Murray and Graves (2012), a safety plan is

> A personalized, detailed document that outlines clear and specific safety strategies that a battering victim can use to promote his/her safety across a wide range of situations. Fundamental to the creation of an appropriate safety plan is a collaborative process to develop it between the client and the professional. (p. 95).

Despite adult safety planning's widespread use, the needs of children in safety planning are complex, controversial, and to date have received limited attention. Kress, Adamson, Paylo, DeMarco, and Bradley (2012) outlined practical suggestions for conducting safety planning for children and adolescents impacted by family violence. The practical suggestions outlined by Kress et al. (2012) included connecting clients with community resources, identifying safe locations during violent incidents, helping children address any trauma-related symptoms they experience, and strengthening child and adolescent's social support resources. Kress et al. (2012) also note the importance of attending to children's developmental stages during the safety planning process in order to insure that all interventions used are appropriate for children's cognitive capacities.

The extent to which children should be involved in safety planning is controversial, in that children should not be expected to be responsible for their own safety to the extent that it is a parental responsibility to do so. Nonetheless, there are developmentally-appropriate ways to address safety issues with children, such as role playing safety behaviors (Kress et al., 2012). One approach to safety planning with children is to use a more generalized intervention that addresses safety behaviors broadly to all children, not specifically addressing IPV (Miller, Howell, Hunter, & Graham-Bermann, 2012). For example, children may learn in a classroom setting about how to find a safe space, call for help, and stay out of adults' fights (Miller et al., 2012). This sort of intervention may also be used with children specifically impacted by parental IPV (Miller et al., 2012). When it is safe to do so, children's parents should be involved in creating safety plans for children (Kolar & Davey, 2007) and can practice safety strategies with their children (Kress, Protivnak, & Sadlak, 2008; Kress et al., 2012).

The effectiveness of safety planning with children has received some attention. Currier and Wurtele (1996) studied the impact of a parent-taught safety program for a total of 26 children, half of whom had been sexually abused. The program resulted in the children in both groups becoming more knowledgeable and skilled in safety behaviors, and the parents did not report any negative reactions to the program by the children. Carter, Kay, George, and King (2003) conducted a pilot evaluation of an intervention for children who had been exposed to IPV. Safety planning and other treatment were also done with the child's parent who was the victim of the IPV. The intervention was shown to increase the participating children's ability to use a safety plan, at least based on their parents' ratings of their children's knowledge of safety planning.

Despite these above reviewed studies indicating that child safety planning can be useful, it is unclear how child safety planning is understood and implemented in the field. Many shelter protocols recommend child safety planning (Gewirtz & Menakem, 2004), but it is unclear if in practice this is being done in the context of the parent's safety planning, more individually with the child or adolescent, and/or more broadly in a community environment, such as a school safety training program as described above by Miller et al. (2012). Further, some shelters have policies against accepting teen boys into the shelter, so it is unclear how practitioners in the field are addressing adolescent boys' safety planning needs (Lyon, Lane, & Menard, 2008; Washington State Coalition Against Domestic Violence, 2003).

3. Methodology

In an effort to (a) address the current limited body of research on IPV-related safety planning for children, (b) identify current practices being used in the field to address children's needs during safety planning, and (c) examine provider perceptions of the most pressing safety-related needs of children that should be addressed in IPV-related safety planning, the authors obtained IRB approval and conducted a series of nine focus groups with domestic violence service providers.

This study was part of a broader study on safety planning conducted by the Family Violence Research Group at the University of North Carolina at Greensboro. The group consisted of a university professor who specializes in research on IPV, doctoral and master students interested in family violence research, and local family violence practitioners. Group members met regularly and discussed their questions about current practices in safety planning for both adults and children. This article addresses the child safety planning portion of the study; the adult safety planning article is discussed in Murray et al. (in press).

The child-specific safety planning focus group questions included: 1) “What do you view as the biggest safety considerations for domestic violence victims and their children?”, 2) “Are the needs of children addressed currently in your agency's safety planning procedures and if so, how?”, and 3) “In particular, are the safety planning needs of older boys in shelter or who aren't eligible for shelter addressed?”.

3.1. Participants

Focus groups were conducted on-site at domestic violence agencies across central North Carolina. We invited a diverse group of domestic violence agencies to participate, including those with and without shelters, those representing urban and rural communities, standalone agencies and those connected with other services (e.g., mental health agencies), and agencies with varying amounts of resources. All nine