

Addressing Child Exposure to Violence

Caitlin DeLong, M.A. and Megan Alderden, Ph.D.

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Research and Analysis Unit

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Children are more likely to be exposed to violence than adults in the United States.¹ According to the 2011 National Survey of Children's Exposure to Violence, 41 percent of children under 17 years old experienced physical assault, 14 percent suffered maltreatment by a caregiver, and 6 percent were sexually victimized in the past year.² Exposure to violence can result in emotional, social, and behavioral problems, academic struggles, cognitive delays, and other health consequences.³ An analysis of 34 studies found about one-third of children exposed to trauma developed posttraumatic stress disorder (PTSD).⁴ Research also demonstrates that exposure to violence can damage the child's sense of safety and weaken child-caregiver attachments in ways that are long-lasting and disruptive, more so than physical injury.^{5,6} Additionally, weakened attachment to one's caregiver has been found to increase the risk of intergenerational transmission of violence.⁷

Illinois' Safe from the Start Program

In 2001, the Illinois Violence Prevention Authority and later the Illinois Criminal Justice Information Authority (Authority) administered funds from the U.S. Office of Juvenile Justice and Delinquency Prevention and the Chicago Department of Public Health to develop pilot programs to address violence exposure in children. Specifically, Safe from the Start (SFS) programs were funded to provide treatment services and supportive referrals to children subjected to violence and their families. By 2009, 11 sites were being funded by the Authority.⁸ SFS goals include:

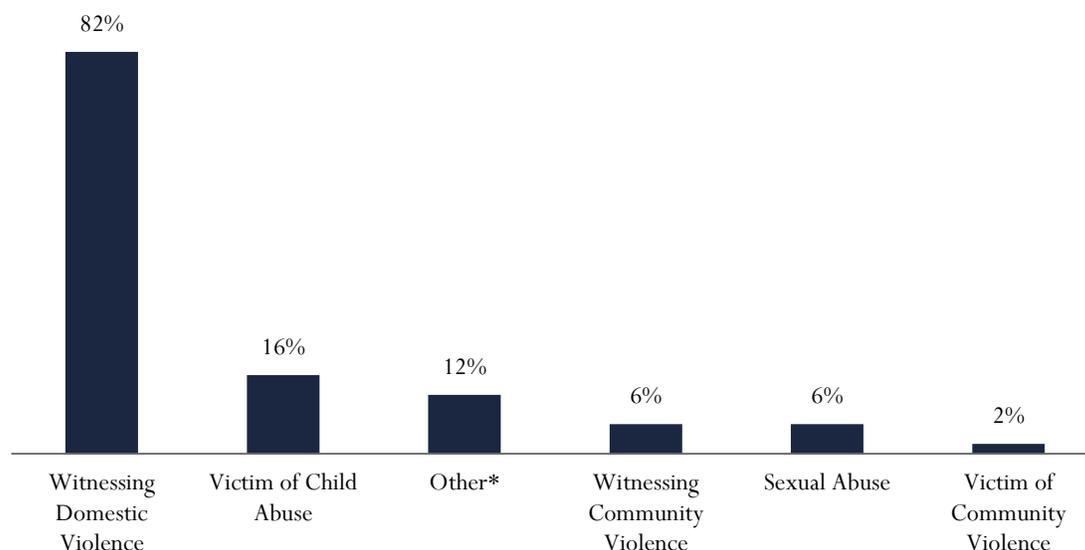
- Early identification and increased services for at-risk children and families.
- Involving children under 6 years of age in developmentally and culturally appropriate interventions that are evidence-based.
- Capitalizing on the strengths of families and including support networks in services.
- Engaging in cross-system collaboration at the state and local levels (including training, technical assistance, and resource development) to establish effective systems of care throughout the domains of law enforcement, education, mental health, and human services.^{9,10,11,12}

From 2001 to 2014, Illinois SFS programs served 4,691 children—32 percent were white, 30 percent were black, and 25 percent were Hispanic. Fifty-two percent of children were male and the average age was five years old. More than half of client households had annual incomes of less than \$15,000 (57 percent) and 43 percent of the children lived with their mothers at the time of intake.¹³ Although the program was focused on violence-exposed children under six years of age, siblings also received treatment, regardless of age.

Figure 1 presents the types of violence children were exposed to, as reported at intake. Domestic violence was the most common type reported (82 percent), followed by child abuse (16 percent). Twenty-three percent reported experiencing more than one type of violence exposure. When caregivers were asked to identify their child's behavioral or emotional symptoms, the most common problems noted at intake were clinging behavior (46 percent), aggression toward siblings (43 percent), and sleep difficulties (39 percent). On average children experienced at least six of 23 adverse child experiences that put them at risk for future health problems, the most common of which were high caregiver distress (62 percent), poverty (61 percent), and having a father in jail (55 percent). Children attended an average of 12 sessions; caregivers attended an average of 10.¹⁴



Figure 1
Type of Violence Exposure Reported at Intake, FY 2014



*Other includes neglect, witness to suicide, sexual abuse of sibling, witness of child abuse, victim of kidnapping, suspected sexual abuse, at-risk for abuse, police raid of home, emotional abuse, and family drug abuse.

Outcomes associated with Illinois SFS programs

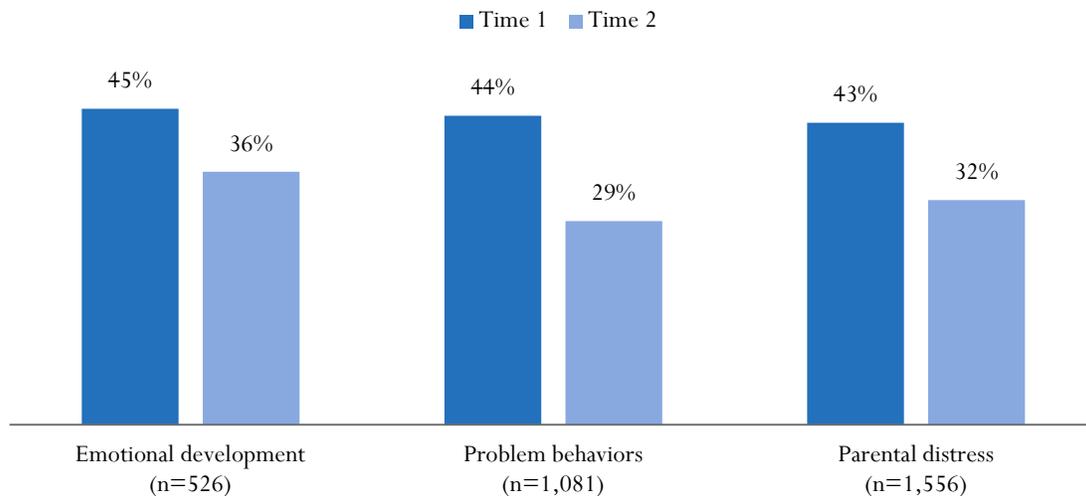
The Authority awarded a grant to the University of Illinois at Chicago to complete a SFS evaluation report, examining services from Fiscal Years 2001 to 2014 across all 11 sites. Findings from this study, taken together with two national studies on SFS sites and other published research on SFS programs suggest that families involved in SFS services experienced reductions in trauma-related symptoms.

Simple analyses comparing baseline behavioral health scores of Illinois SFS program participants to those with assessments scores after five to 10 sessions indicate notable reductions in social-emotional delays, problem behaviors, and parental stress (*Figure 2*).¹⁵ These findings were mirrored in national studies that found SFS programs improved identification of and service delivery to at-risk children and reduced trauma and stress symptoms in families.¹⁶ Importantly, the national studies included matched control groups, a research design that allows for greater confidence in reported findings. Illinois SFS providers also documented that caregivers acquired knowledge on natural developmental stages of children and youth were better able to identify their own feelings. Greater improvements in these areas were associated with more session attendance.¹⁷

While the specific modes of therapy varied by Illinois SFS provider, researchers were able to pinpoint topics that were common throughout the 11 sites. Analyses of these common topics revealed that the greatest improvement in child health measures were associated with services dedicated to the healthy expression of emotion, good and bad touches, and learning about the cycle of violence. Services that focused on the effects of violence exposure, sexual abuse, support networks, and grief/loss were correlated with the largest gains in caregiver stress relief, while caregiver services focusing on appropriate discipline were associated with improved child behavior measures.¹⁸



Figure 2
Changes in Client Assessment Scores
Time 1 and 2



Researchers also found higher treatment completion rates nationally when multiple treatment formats are used (such as individual and family treatment),¹⁹ a finding also noted when examining the data for Illinois SFS programs.²⁰

Limitations to existing research

While data on the background characteristics of the clients served and the SFS program outcomes indicate the need for trauma-informed services for this population, the research falls short of identifying precisely the services needed and the appropriate modality. Despite the overwhelming amount of information collected for this program on the experiences of the children and families that are exposed to violence, the SFS evaluation does not include enough data on the provider’s therapeutic process for this program to be replicated with fidelity. Additionally, much of the data examined was collected by providers, who may display bias towards positively evaluating one’s work.²¹ Family reports also may become skewed as caregivers are educated on the effects of violence and become more sensitive to them, and clients who exhibited low level symptoms at baseline may not have much “room” to improve and affect outcome data.²²

The research reviewed here for Illinois is also limited because of data availability. Low rates of follow-up assessment prevent researchers from fully understanding the impact of SFS programming because self-selection biases may occur as clients opt out of programming. Of the 4,691 children assessed by the program, only a sub-sample of those children had completed baseline assessments (Time 1) and even fewer had completed assessments at post-intervention (Time 2).

Implications for policy and practice

- Programs should strengthen client retention. Many families did not attend the minimum of nine sessions associated with improvements in the child behavior scores.²³ SFS families face numerous barriers to service completion, including transportation, job instability, and housing uncertainty. An analysis of 17 studies



attempting to maintain client engagement in parent-child mental health programs found that successful interventions addressed both practical and psychological barriers early and used motivational interviewing, family systems therapy, and coping support strategies.²⁴ Programs should also engage in treatment activities that promote client retention. This includes ensuring programming is culturally sensitive and uses multiple treatment formats.

- Programs should be flexible. This may be particularly important when serving families with multiple needs. Programs should use multiple methods of contact to assist in retention efforts as many families served by SFS programs also face employment and housing instability, factors that may inhibit treatment completion. Regularly confirming contact information, collecting multiple types of contact information, and being flexible when scheduling assessments and treatment succeeded in raising treatment completion rates in national sites.²⁵
- Programs should foster partnerships between caregivers and professionals. SFS program data indicated child behavior and development scores and caregiver stress scores were related to one another.²⁶ Research supports the need for partnership between professionals and individuals caring for children coping with trauma in the home environment.²⁷ The relationship fosters trust, critical listening skills, respect, empathy, and sharing of expertise for both parties, building a support network for emergencies and increasing caregiver confidence. Research has shown caregivers who are fully engaged in SFS programming that promotes caregiver-child attachment help children process trauma in a healthy way²⁸ and resist future delinquency.²⁹
- Programs should engage communities. The partnerships developed by SFS stakeholders to increase detection of and services to at-risk children and families should be maximized for the benefit of all children in the community. SFS programs are uniquely situated to engage communities in outreach efforts that can help increase community awareness of the consequences of child exposure to violence and foster additional community support for at-risk families.³⁰

¹ Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., & Kracke, K. (2009). *Children's exposure to violence: A comprehensive national survey*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

² Finkelhor, D., Turner, H. A., Ormrod, R. K., & Hamby, S. L. (2013). Violence, crime, and exposure in a national sample of children and youth: An update. *Pediatrics*, *167*(7), 614-621.

³ Wolfe, D.A., Crooks, C.V., Lee, V., McIntyre-Smith, A., & Jaffe, P.G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review*, *6*(3), 171-187.

⁴ Fletcher, K. E. (2003). Childhood posttraumatic stress disorder. In E. J. Mash, & R. A. Barkley (Eds.), *Child psychopathology* (pp. 310–371). (2nd ed.). New York: Guilford Press.

⁵ Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology*, *22*(1), 87-108.

⁶ Laan, P. H., Put, C. E., Dubas, J. S., Hoeve, M., Gerris, J. R. M., & Stams, G. J. J. M. (2012). A meta-analysis of attachment to parents and delinquency. *Journal of Abnormal Child Psychology*, *40*(5), 771-785.

⁷ Sutton, T. E., Simons, L. G., Wickrama, K. A. S., & Futris, T. (2014). The intergenerational transmission of violence: Examining the mediating roles of insecure attachment and destructive disagreement beliefs. *Violence and Victims*, *29*(4), 670.

⁸ Sites included Center for Prevention of Abuse (Peoria, IL); Child Advocacy Center of North and Northwest Cook County (Schaumburg, IL); Phoenix Crisis Center (Granite City, IL); Child Abuse Council (Moline, IL); Macon County Child Advocacy Center (Decatur, IL); South Suburban Family Shelter (Homewood, IL); Family Focus Englewood (Chicago, IL); Metropolitan Family Services (Chicago, IL); Casa Central (Chicago, IL); Children's Home and Aid (Bloomington, IL); and Heartland Alliance (Chicago, IL).

⁹ Schewe, P.A., Chehade, S., et al. (2015). *Safe from the Start, Year 13 Report: 2001-2014*. Chicago, IL: Interdisciplinary Center for Research on Violence at the University of Illinois at Chicago.



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- ¹¹ Kracke, K., Lamb, Y., & Hyde, M. M. (2008). The Safe Start demonstration project: Knowledge building to knowledge transfer for children exposed to violence. *Best Practices in Mental Health*, 4(1), 92-98.
- ¹² Koverola, C., Murtaugh, C. A., Connors, K. M., Reeves, G., & Papas, M. A. (2007). Children exposed to violence: Predictors of attrition and retention in treatment. *Journal of Aggression, Maltreatment, & Trauma*, 14, 19-42.
- ¹³ Schewe et al. (2015).
- ¹⁴ Schewe et al. (2015).
- ¹⁵ Schewe et al. (2015).
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- ²⁰ Risser & Schewe (2013).
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- ²² Jaycox et al. (2012).
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- ²⁹ Hoeve, M., Stams, G. J. J. M., van der Put, C. E., Dubas, J. S., van der Laan, P. H., & Gerris, J. R. M. (2012). A meta-analysis of attachment to parents and delinquency. *Journal of Abnormal Child Psychology*, 40(5), 771-785.
- ³⁰ Schewe et al. (2015).