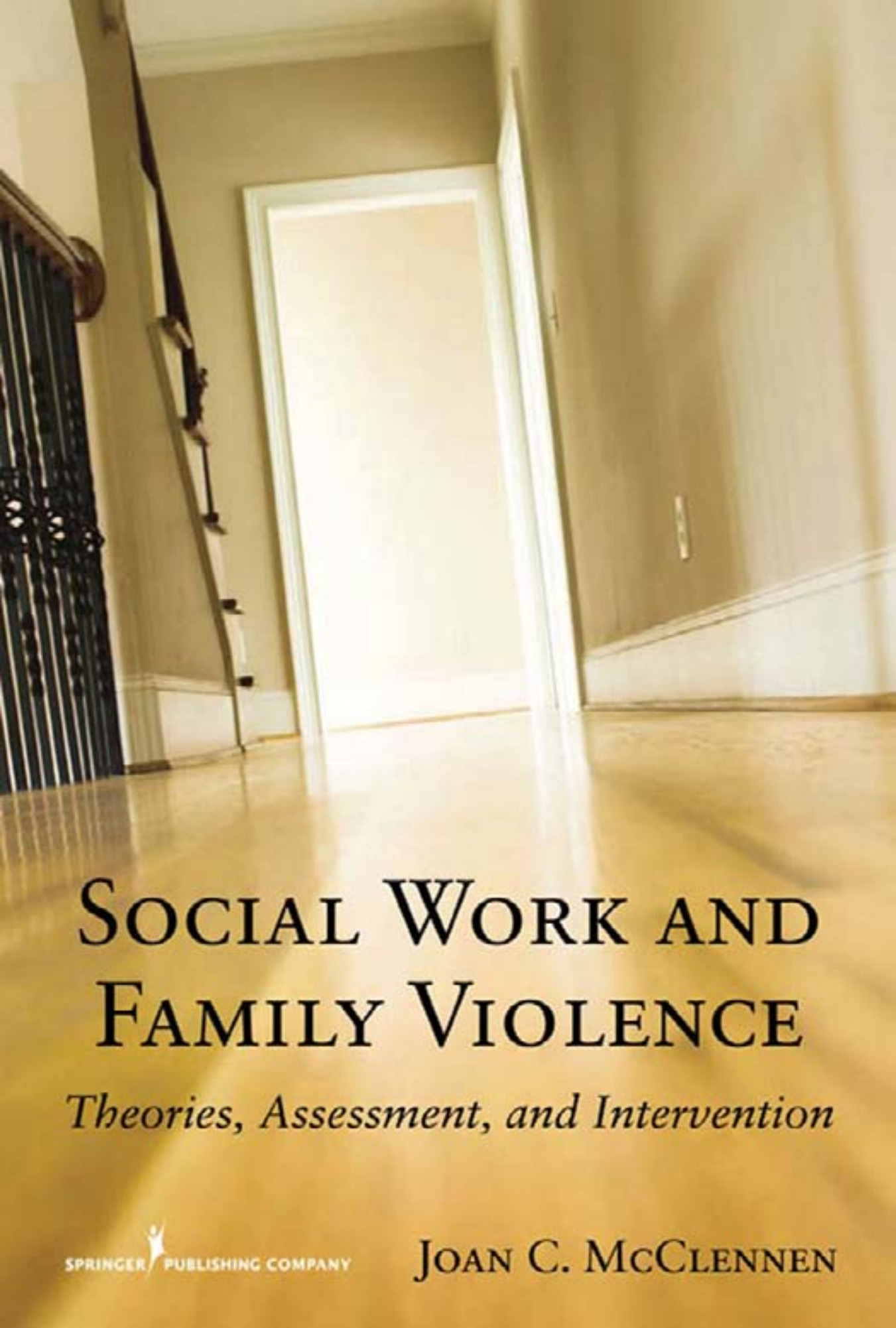

Social Work and Family Violence

Theories, Assessment, and Intervention

SPRINGER PUBLISHING COMPANY

Joan C. McClennen

Social Work and Family Violence

Theories, Assessment, and Intervention

Joan C. McClennen, PhD, is a full professor at Missouri State University. Prior to assuming her academic career, Dr. McClennen held counseling and adminstrative positions in the areas of child abuse, mental health, and children's services. Following an intensive study, she co-edited *A Professional's Guide to Understanding Gay and Lesbian Domestic Violence: Understanding Practice Interventions* as well as numerous articles in professional journals. She is presently co-authoring a book titled *The Human Kinetics Manual* along with studies involving child abuse. Her writing has appeared in the *Journal of Interpersonal Violence*, *Journal of Gay & Lesbian Social Services*, *Family Therapy*, *College Student Journal*, and *Research on Social Work Practice*.

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Contents

Preface

This book is dedicated to all social workers who have committed their lives to enhancing the problem-solving and coping capacities of families, particularly those who are experiencing violence. This book is written by a social worker for other social workers; it specifically focuses on social workers' roles and responsibilities in ending family violence. The contents meet the criteria of the Council on Social Work Education (including a focus on ethics, populations at risk, and diversity), address skills required for successful assessment and intervention practices, and attempt to balance theoretical knowledge with practical application.

The mission of the social work profession is to enhance the well-being of all people—with particular attention to the empowerment of those who are vulnerable—and to advocate for social and economic justice. Social workers provide effective evidence-based, multilevel interventions grounded in a body of knowledge and practice skills infused with professional values that serve all systems levels—individuals, families, groups, organizations, and communities (Kirst-Ashman & Hull, 2009). In addition to meeting these demanding responsibilities, social workers are mandated reporters of child and elder abuse and inevitably are (or will be) confronted with clients experiencing family violence. Having the knowledge and skills to competently provide intervention to families, regardless of the type of violence they are experiencing (child abuse, domestic violence, or elder abuse), can be a daunting task. This book is intended to help social workers make that task achievable.

Topics Covered

Most chapters in this text begin with a true story of family violence. These stories are intended to spark the reader's interest and are used to illustrate the chapter's content. While occasionally graphic, these stories are not meant to serve as sensationalism. Rather, they illustrate real-life events and poignantly demonstrate the need for social workers to intervene in cases of family violence. As a further teaching aid, each chapter ends with discussion questions and key terms.

Chapter 1 provides an overview of family violence and the social work profession. The Family Health Perspective—which integrates the ecological perspective, systems theory, social constructionist theory, and postmodernism—is introduced as the theoretical foundation for this book. The National Association of Social Workers (2008) (NASW) Code of Ethics is also discussed in relation to family violence.

The book then examines three areas of family violence: child abuse, intimate partner violence, and elder abuse. Each section begins with an introductory chapter (chapter 2 for child abuse, chapter 7 for intimate partner violence, and chapter 14 for elder abuse). These chapters discuss prominent theories taught within the curriculum (e.g., systems theory, ecological perspective, and attachment theory); historical developments related to the profession; major legislative actions (e.g., the Children's Abuse Prevention and Treatment Act, the Violence Against Women Act, and the Older American's Act); various types of violence (e.g., physical and psychological); and prevalence reports.

Two separate chapters focus on identifying and investigating areas of family violence for which social workers are mandated reporters—chapter 3 on child abuse and chapter 15 on elder abuse. Both chapters provide detailed indicators of maltreatment. Investigative procedures and risk-assessment instruments are explained in each chapter; those used by Child Protective Services in chapter 3 and those by Adult Protective Services in chapter 15. Ethical dilemmas faced by social workers in these investigatory procedures are discussed, along with potential alternative responses.

Each section also includes a chapter addressing the criminal justice system's role and the responsibilities of social workers within these systems—chapter 4 on child abuse, chapter 9 on intimate partner violence, and chapter 15 on elder abuse. Contents of these chapters include an explanation of court structures and procedures, specialized court services, investigative interviewing, social workers' rights and responsibilities, and the various roles of social workers in the judicial system. Each of these chapters contains issues particularly pertinent to the population being addressed. Chapter 4 includes specialized court services and court testimony issues as they relate to children. Protection orders, responsibilities of court advocates, diversion programs, and mediation are covered in chapter 9. Long-term-care ombudsmen, wards, and guardianship are discussed in chapter 15.

Because abuse and neglect of children has devastating consequences for their emotional and physical development, chapter 5 addresses the symptoms of maltreatment and the services in place to assist these children. Symptoms are categorized by type of abuse experienced, age at the time of intervention, and maladaptive behaviors exhibited (neurobiological, cognitive, physical, and emotional). The continuum of services offered by the child welfare system is presented, including both in-home and out-of-home care alternatives (emergency settings, shared family care, therapeutic care, and long-term foster care). Given that there are roughly 500,000 children in foster care, the chapter presents a detailed examination of the foster care system, including the reasons for placement, problems experienced by children in placement, programs for foster parents, and the importance of collaborative relations between foster parents and social workers.

Four chapters (8 and 11 through 13) focus on different aspects of intimate partner violence. Chapter 8, on the dynamics of domestic violence, addresses the evolving issues of power and control, cycles of violence, learned helplessness, battered woman syndrome, and reasons victims stay. Various power and control wheels and phases in the cycle of violence, along with modified alternatives, are presented.

Chapter 11, which focuses on child witnesses of domestic violence, begins with a clarification of the definition of children who witness domestic violence

as well as factors influencing the impact of domestic violence on child witnesses. Assessments and interventions are also discussed.

Chapter 12, on perpetrators of intimate partner violence, explains their characteristics as well as the role of substance abuse in family violence. Typologies of perpetrators are explained by their various dimensions, which include severity of violence, generality of violence, psychopathologies, and different models such as the intraindividual, interpersonal, and sociocultural. The assessment of perpetrators involves specialized techniques for engaging them in the treatment process as well as the use of various interview questions and standardized instruments to determine their lethality and motivation to change. Various treatment approaches are also discussed.

Chapter 13, on victims of intimate partner violence, provides insight into the special problems that these individuals experience. The impacts of domestic violence on at-risk populations—including women on welfare, rural women, women with disabilities, and older women—are explored. Adolescent dating violence is discussed, including abusive strategies, correlates, and safety plans. Distinctions between female and male perpetrators are briefly addressed. Information is provided to assist social workers in intervening with families from diverse ethnic cultures, including immigrant, Asian American, African American, and Hispanic families. Finally, while same-gender domestic violence is discussed in several chapters, this topic is addressed in detail in chapter 13. For over 5 years, the author researched this issue with the support and assistance of hundreds of gay men and lesbians throughout the United States. Existing research on prevalence, help-seeking behaviors, and interventions is discussed as well as recommendations for future research.

Three chapters present evidence-based assessments and interventions. Chapter 6, on children, contains assessments using standardized instruments and structured observations as well as therapeutic approaches by type of abuse and type of treatment strategy. This chapter also includes a section on adult survivors of child maltreatment, which presents their symptom and recovery stages as well as assessment tools and therapeutic strategies for social workers to use in helping them.

Chapter 10, on assessment and interventions for victims of intimate partner violence, includes the "deficit model" (Goldner, 1999): determination of danger, specific questioning, standardized measures, and diagnostic techniques. Interventions explain the safety plan, characteristics of victims, and therapeutic approaches.

Chapter 16, on assessment and intervention for victims of elder abuse, stresses the need for capacity assessments (Moye & Marson, 2007) and standardized instruments for identifying older people at risk for maltreatment; it also describes assessment techniques for identifying abusive caregivers. Therapeutic approaches that address "caregiver stress" versus "abuser impairment" (Brownell & Wolden, 2002) are presented, and the ideological debate of protection versus self-determination is discussed.

Chapter 17, the final chapter, focuses on the prevention of family violence. Conservative annual estimates suggest that 4 to 9 million people are victims of family violence, and 171 million (or 60% of the population) are at risk for violence. The estimated cost of these acts of violence to taxpayers easily exceeds $1 trillion a year (Dubble, 2006; Thomas, Leicht, Hughes, Madigan, & Dowell, 2003). Various government programs and national advocacy agencies

are dedicated to prevention efforts, and their efforts are summarized in this chapter.

Audiences

The primary audience for this book includes bachelor of social work (BSW) and master of social work (MSW) students. In addition, the contents can help practicing social workers who are interested in increasing their knowledge about family violence.

In colleges and universities, this book may serve as a primary text for courses addressing family violence (i.e., child abuse, domestic violence, and/or elder abuse) and a possible complementary text for Practice with Individuals; Practice with Groups; and Field Practicum. For BSW students, the book presents fundamentals including types, histories, policies, prevalence, indicators, investigative procedures, dynamics, and the criminal justice system. For MSW students, the text presents more complex aspects including assessment tools, intervention techniques, and testifying as an expert witness.

Family violence issues are applied to the NASW Code of Ethics and integrated into the nine curriculum areas within BSW and MSW programs approved by the Council on Social Work Education (CSWE). Theories commonly taught within the curriculum provide a foundation for comprehending behaviors of victims and perpetrators. The historical development of the profession is related to the development of interventions on behalf of victims.

An Instructor's Manual for *Social Work and Family Violence* is available for professors who wish to utilize this text in a course. Qualified instructors may e-mail textbook@springerpub.com to request a copy.

Integrating Family Violence Into the Social Work Curriculum

Overview of the BSW Curriculum

BSW students are educated to be generalist practitioners in accordance with regulations of the CSWE, which is the accrediting body for social work programs in higher education. Generalist social work practice uses an eclectic knowledge base, professional values, and a range of skills to solve social problems at all systems levels (individual, family, groups, organizations, and communities) (Kirst-Ashman & Hull, 2009). This knowledge base for social work, with its accompanying skills and abilities, are taught using nine CSWE curriculum areas:

- Human Behavior and the Social Environment
- Diversity
- Populations at Risk
- Values and Ethics
- Social and Economic Justice
- Policy
- Research

- Practice With Individuals, Families, Groups, Organizations, and Communities
- Field Practicum

The information from the curriculum must be demonstrated in the 12 essential skills of the social work profession. These skills include:

- Listening
- Assessing information
- Creating professional relationships
- Interpreting behavior
- Engaging clients
- Discussing sensitive subjects
- Creating innovative solutions to needs
- Terminating
- Conducting research
- Negotiating
- Providing liaison services
- Communicating needs

The skills and curriculum areas are integrated into seven problem-solving steps for working with clients—engagement, assessment, planning and contracting, implementation, evaluation, termination, and follow-up.

Overview of the MSW Curriculum

The general goals of an MSW program include preparing graduates to practice with (a) client systems of various sizes and types; (b) diverse populations; (c) an understanding of the social context of social work practice, the changing nature of those contexts, the behavior of organizations, and the dynamics of change; (d) infusion of professional values and ethics; and (e) an increased awareness of their continued responsibility for professional growth and development.

Graduates of MSW programs are prepared for advanced responsibilities in various areas including advocacy, administration, community planning and development, and direct practice. If they are interested in direct practice, social workers are encouraged to work under a qualified supervisor and pass their state's social work examination to become licensed social workers. Similar opportunities are available for social workers concentrating in other areas of practice (e.g., communities and organizations, substance abuse, social work with the elderly).

Integrating Knowledge and Skills for Family Violence Intervention

The social workers of the future must be capable of integrating the knowledge, skills, and abilities learned in their course work for effective intervention with

clients experiencing family violence. The foundation courses for BSW and 2-year MSW (those having an undergraduate degree other than social work) students include seven content areas. Within these, students must master 10 core competencies.

Foundation Curriculum Content

The circle of "Integration of Family Violence Content into the Social Work Curriculum" (Figure FM.1) is an adaptation of the "Infusion of Domestic Violence

FM.1

Infusion of domestic violence content across the social work foundation curriculum. Developed by Fran Danis, PhD, Associate Dean of Social Work at the University of Texas at Arlington.

Content in the Social Work Foundation Curriculum" by Danis (2002) and serves as a snapshot of the content taught within the social work foundation curriculum as applied to various issues related to family violence. In brief, the curriculum content can be summarized as follows:

- Human Behavior and the Social Environment focuses on the theoretical underpinnings of family violence.
- Social Welfare Policy and Services covers governmental policies influencing families experiencing violence.
- Diversity and Populations at Risk, along with Social and Economic Justice address family assessment and intervention as dependent upon persons' culture, spiritual beliefs, financial status, or other differentiating means among populations.
- Research develops means for assessing community needs and meeting these needs based on evidence-based practice.
- Values and Ethics are infused into the curriculum to guide future social workers in their critical thinking and decision making as they balance the protection of victims with the reunification of families.
- Practice classes provide an opportunity for students to implement theory into the practice situations within multisystem levels, thereby enhancing their abilities to practice competently with individuals, families, and groups within an organizational setting using community involvement.
- Field Practicum provides an opportunity for students to practice in an actual placement while still under supervision.

MSW students are required to show evidence of integrating the curriculum content into practice on a more advanced level than are BSW students. However, all professional social workers are mandated reporters and inevitably will work to some extent with families experiencing family violence.

Educational Policy and Accreditation Standards

The Council on Social Work Education (CSWE; 2001, p. 3) developed the Educational Policy and Accreditation Standards (EPAS) for the accreditation of social work programs. BSW and MSW students must demonstrate mastery of core competencies. "Competency-based education is an outcome performance approach to curriculum design. Competencies are measurable practice behaviors that are comprised of knowledge, values, and skills" (Council on Social Work Education, 2008, p. 3). These practice behaviors include the following:

- Identify as a professional social worker and conduct oneself accordingly
- Apply social work ethical principles to guide professional practice
- Apply critical thinking to inform and communicate professional judgments
- Engage diversity and difference in practice
- Advance human rights and social and economic justice
- Engage in research-informed practice and practice-informed research
- Apply knowledge of human behavior and the social environment

- Engage in policy practice to advance social and economic well-being and to deliver effective social work services
- Respond to contexts that shape practice
- Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities

Professors who wish for more information and tools to integrate *Social Work and Family Violence* into their course should refer to the Instructor's Manual. Qualified instructors may e-mail textbook@springerpub.com to request a copy.

Unique Contributions of This Text

Investigations into reports of family violence can help social workers gain insight and knowledge regarding their various roles and responsibilities. For example, mandated reporting of abuse includes issues of privileged information, conflict with therapeutic confidentiality, and ethical dilemmas. Investigatory procedures detail Child Protective Services and Adult Protective Services' risk assessments, stepwise interviewing process, and mutual responsibilities within these programs. The criminal justice system is a venue for understanding and guiding social workers' roles within various types of courts, investigative interviewing, and court appearance from preparation to testifying, protective and other court orders, collaboration with specialized court services, preparation of children for court appearances, diversionary programs, mediation, and other knowledge necessary to the profession.

Assessments and interventions are provided not only for the adult victims of family violence but also for adult survivors of child abuse, child witnesses of domestic violence, adolescent victims of dating violence, and perpetrators of abuse. Assessment procedures include specific standardized instruments, stages of assessment, specific questions for approaching victims and perpetrators, and diagnosis. Therapeutic approaches include various types of interventions depending upon the chosen theoretical foundation and their corresponding techniques.

This book covers a broad range of vulnerable populations and addresses their needs for particular services, legislative action on their behalf, and strategies for effective intervention. Some of these populations include women on welfare, older battered women, rural women, female perpetrators, and persons with disabilities.

The author's personal and professional experiences provide information about gay and lesbian communities that add considerably to this book's resources. The results of this research, which have been published and continue to be presented at numerous conferences, include unique barriers, theoretical perspectives, differentiation between victims and perpetrators, assessment tools, and empowerment strategies.

This text will have served its purpose well if it helps prospective and current social workers develop the knowledge, skills, and motivation needed to advocate on behalf of the social and economic justice of those we serve and particularly those who are vulnerable.

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Introduction to Family Violence

1

Conservative annual estimates suggest that 4 to 9 million people are victims of family violence and 171 million (or 60% of the population) are at risk of violence. The estimated cost of these acts of violence to taxpayers easily exceeds $1 trillion a year (Dubble, 2006; Thomas, Leicht, Hughes, Madigan, & Dowell, 2003). Family violence affects everyone, either directly or indirectly.

In this book, attention is given to child maltreatment, intimate partner violence, and elder abuse. Although these three categories are discussed separately, they are interconnected. Adults who were abused as children have a high probability of becoming abusive parents, victims or perpetrators in abusive intimate relationships, and victims of elder abuse. Although far from inevitable, the pattern of intergenerational violence affects millions of families annually (Hurley & Jaffe, 1999). Furthermore, families may be affected by multiple forms of violence occurring simultaneously.

This chapter introduces family violence and the general perspective from which the book is written. Its theories, values, and contents are based on the family health perspective, the National Association of Social Workers' Code of Ethics, and accreditation materials from the Council on Social Work Education.

Categories of Family Violence

Child maltreatment or **child abuse** includes any nonaccidental injury to a child by an adult and, according to the Federal Child Abuse Prevention and Treatment Act (CAPTA), is categorized as physical, sexual, and/or emotional abuse as well as neglectful acts (Massey-Stokes & Lanning, 2004). Over 3.3 million reports of abuse are made annually in the United States, representing an estimated 905,000 children as victims, or 12.1 victims per thousand children. Every day 4 children die as a result of child abuse (*Child Maltreatment Report*, 2006).

Intimate partner violence (IPV), sometimes referred to as **domestic violence** (DV), is any act of commission or omission against an intimate partner using a complex pattern of physical, sexual, psychological, and/or economic behaviors devised and carried out to control and abuse a partner (Healey, Smith, & O'Sullivan, 1998). Annually in the United States, 1 out of every 4 women reports being a victim of intimate partner violence with a male as the perpetrator (Tjaden & Thoennes, 2000).

Elder abuse, also referred to as *mistreatment of older adults* (Lithwick, Beaulieu, Gravel, & Straka, 2000) and *elder mistreatment* (Loue, 2001), is "any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult" (National Center on Elder Abuse, n.d.) occurring to individuals 60 years of age and over. These acts can occur in persons' homes or in institutional settings. Elder abuse includes at least seven common types: physical, emotional or psychological, sexual, financial or other material exploitation, abandonment, neglect, and self-neglect (Jogerst et al., 2003). Although statistics and definitions of elder abuse vary, it is estimated that every year, 600,000 older adults are victims of elder abuse (Teaster et al., 2006).

Family Health Perspective

The **family health perspective** (Pardeck & Yuen, 1997), the foundation for this book, defines a family as a system of two or more interacting persons who are related by ties of marriage, birth, adoption, or personal choice and have committed themselves to each other as a unit for the common purpose of promoting the physical, mental, emotional, social, cultural, financial and spiritual growth and development of each unit member. This definition goes beyond the traditional definition of a family as a husband and wife with children. Family is self-defined by the individual whether the other members are human (most common), animal (less common), or deceased individuals who formed the person's persona. Following this broader definition, family can include same-gender, not-legally-married, and any other committed couples whether or not they have children.

The family health perspective is based on an integration of the biopsychosocial and ecological perspectives, systems theory, social constructionist theory, and postmodernism (Pardeck & Yuen, 1997). It emphasizes the importance of focusing on clients' total well-being (physical, psychological, mental, spiritual, financial, social, and cultural), allows clients to interpret their own levels of health, and stresses the importance of understanding clients as they influence and are influenced by their families and society.

As components of the family health perspective, systems theory and the ecological approach are concerned with humans as they interact with each other and the world around them. The ecological approach assumes that the environment is embodied by living and dynamic interactions, whereas social systems theory assumes that the environment also includes inanimate operations (Kirst-Ashman & Hull, 2009). These theories apply to interventions that take place at any level (micro, mezzo, or macro); thus they help social workers to integrate those therapeutic approaches that are most appropriate for their clients and to attend to environmental policies and planning activities that will enhance their clients' total well-being.

The importance of the social construction theory and postmodern perspective is their emphasis on the ability of individuals to interpret their own reality and on the celebration of diversity. These theories are in keeping with the profession's values of the dignity and worth of all persons and the importance of human relationships. These values are reflected in the National Association of Social Workers' Code of Ethics as to self-determination (Standard 1.02), cultural competence, and social diversity (Standard 1.05).

Family Violence and the NASW Code of Ethics

The commitments to clients (Standard 1.01) as well as to social and political action on behalf of vulnerable populations (Standard 6.04) align the family health perspective with the **National Association of Social Workers' (NASW) Code of Ethics**. It provides the values, ethics, and conduct to be adhered to by social workers, among which is the commitment of service to help families experiencing family violence. These values and ethics have been adapted into principles congruent for social work within the area of family violence (see Table 1.1).

Social Workers and Family Violence

With their professional mission to serve vulnerable populations—which is inclusive of children, women, and the elderly—social workers are at the forefront of the effort to eliminate family violence. According to the Child Abuse Prevention and Treatment Act, social workers are legally mandated to report abused and neglected children (Herman, 2007); according to the Older Americans Act, they are legally mandated to report abused older adults (Roby & Sullivan, 2000) to, respectively, Child Protective Services (CPS) and Adult Protective Services (APS). Failure to comply with these mandates can result in expulsion from the profession, loss of licensure, and both criminal and civil action. In consideration of these responsibilities, social workers must be adept at assessing and intervening for victims of family violence.

1.1 Social Work Code of Ethics: Values, Ethics, and Principles as Applied to Family Violence

Values	Ethics	Principles
Service	Social workers' primary goal is to help people in need and to address social problems.	Social workers will use their knowledge, values, and skills to address the social problem of family violence (FV). They will sometimes provide this help with no expectation of remuneration.
Social justice	Social workers challenge social injustice.	Social workers will pursue necessary changes on all systems levels on behalf of victims and perpetrators of FV. These change efforts must be adapted so as to be culturally sensitive. While assisting in this endeavor, social workers are to empower clients for self-advocacy and to assure clients' equal access to information, services, and resources for discontinuing FV.
Dignity and worth of the person	Social workers respect the inherent dignity and worth of the person.	Social workers treat each person, including victims and perpetrators of FV, in a respectful manner. Interactions are to be culturally sensitive. Social workers promote victims' self-determination and seek to empower victims and their families' abilities to meet their needs toward obtaining total well-being.
Importance of human relationships	Social workers recognize the central importance of human relationships.	Social workers value relationships between and among victims of FV, their perpetrators, and professionals. Social workers seek to strengthen these relationships and to enhance the helping process of promoting, restoring, maintaining and enhancing the well-being of FV victims and their families.
Integrity	Social workers behave in a trustworthy manner.	Social workers act in a manner consistent with the Code of Ethics and will, thus, be honest and responsible in working with clients experiencing FV.

1.1 (continued)

Values	Ethics	Principles
Competence	Social workers practice within their areas of competence and develop and enhance their professional expertise.	Social workers will increase their knowledge and skills for assisting victims of FV and their families. They will use literature in professional journals as well as other resources for maintaining and improving their professional competence in this area.

These assessment and intervention processes are assisted by the family health perspective, with its fluid definition of a family, evaluation of all aspects of the family's health, and consideration not only of the family interactions but also of the family in relation to all levels of systems, even into the global community. Assessment of families can be in relation to their physical health (Wu et al., 2004), emotional health (Russell, Lazenbatt, Freeman, & Marcenes, 2004), mental health (Stipanicic, Nolin, Fortin, & Gobeil, 2008), spirituality (Sadler & Biggs, 2006); financial status (Kaushal, Gao, & Waldfogel, 2007), social relationships (Woods & Kurtz, 2007), and cultural issues (Roby & Shaw, 2006). Family assessment instruments continue to be developed in efforts to help professionals to determine the risk of maltreatment (Dorsey, Mustillo, Farmer, & Elbogen, 2008). Deciding when to act and what action to take requires social workers to use critical thinking, which integrates values, ethics, policy, and research (Gray & Gibbons, 2007). The family health perspective provides this foundation for taking the appropriate action.

Summary

Despite increased attention to the assessment and intervention of family violence as well as countless federal, state, and local efforts to stop family violence, its existence seems perpetual—perhaps indicative of increased reporting, inadequate funding, and an endemic culture of violence.

Social workers are committed to help vulnerable populations, which include the victims of family violence. By law, social workers are mandated to report suspected abuse and neglect of children and elderly adults. By their professional code of ethics, they are responsible for being knowledgeable on various aspects of family violence, thus enabling them to help victims and their abusers. Social workers are joined by dozens of other kinds of professionals in their efforts to prevent and intervene in family violence for the enhanced well-being of all.

Fateful Day Slips Into Past

It's always in the back of Tracy Cassidy's mind, the night her daughter was kidnapped and almost killed. She finds herself thinking about it while watching 6-year-old Ivie playing with the cat or skipping around their home. She thinks how lucky they were. It crosses Ivie's mind, too, though it's hard to detect. She's the same happy, outgoing little girl she was before the incident, but when her mother starts talking about it, she gets quiet. "Stop talking about that," she said Thursday, and went to find the cat.

Who could blame her? It was, after all, only a year ago that three fishermen found Ivie Genone floating below a bridge on McDaniel Lake. Her mother's estranged husband had kidnapped the girl from her Springfield home earlier that morning. He beat the 5-year-old before dropping her in the lake, so she had bruises on her face when the fishermen's flashlights spotted her early Sept. 6.

Had the men not heard Ivie's muffled voice and a splash that dark morning, she probably would've drowned. "I'm not sure she realizes that," Cassidy said Thursday. "I think she thinks he just wanted to hurt her."

A lot happened the year that followed. Johnnie Jerome Kerns is now serving 70 years in prison. Cassidy and her daughter have resumed their regular lives. Ivie is in kindergarten. Cassidy is engaged to be married again. "We're totally over the whole situation," said Cassidy, 26. "It doesn't affect her, but she'll bring it up once in a while."

Late-Night Noise

The ordeal began shortly after 1 A.M. on Sept. 6, 2006. Cassidy was out with her boyfriend, and Ivie was home with a sitter—one of Cassidy's friends. The sitter would later tell Cassidy she heard a noise around 1:30 A.M. but didn't think to check on it. When she found Ivie was gone, the sitter assumed Cassidy had come to take her elsewhere. Cassidy and the woman are no longer friends.

What the sitter heard was Kerns, who later told police he had come to the home to kill Cassidy. The two had split up months after Kerns abused her. She had recently changed her number and filed for divorce. When he found his wife not at home, Kerns took Ivie. The girl didn't know to distrust her stepfather. "There was never that conversation," Cassidy said. "I didn't think they'd ever see each other again."

Heroic Fisherman

It's unclear what happened in the hours after the kidnapping, but about 5:30 A.M. fishermen Don Stidham, Ric Norman, and Gary Porter saw a car

(continued)

stop abruptly on a bridge over McDaniel Lake. They heard a girl talking, but it seemed her voice was suddenly muffled. Then came two splashes. They ran to the bridge, and when Stidham asked Kerns what was going on, the kidnapper said he was getting rid of some old tires. He sped off. Then the fishermen saw the girl floating in a strong current under the bridge. The other splash had come from an old tire with rope. When Stidham asked the girl who'd thrown her into the water, she said, "John." Kerns was in police custody within hours. He was convicted of kidnapping and assault in February.

Resilient Child

In the days after the incident, Ivie talked to a therapist about her feelings. But she seemed remarkably unchanged by the events, said Cassidy, who soon discontinued the treatment. In fact, the only real change in Ivie's life these days is her mother's stalwart overprotectiveness, Cassidy said. "Ever since it happened, we don't go out on evening adventures without her," she said. "Of course, I spoil her rotten. She's just the happiest kid ever."

As it was before Ivie's harrowing ordeal, life is good again in Cassidy's home. And with a lengthy prison sentence separating mother and daughter from their would-be killer, there's no reason for Cassidy to think that's about to change. Kerns must serve at least 85 percent of his sentence, meaning he'll be in prison until he's at least 89. "He was sentenced to 70 years," she said. "You can't beat that." (VanderHart, 2007)

—Reprinted from the September 7, 2007, issue of the *Springfield News-Leader* (MO).

Discussion Questions

1. What are the various types of child abuse Ivie experienced as presented in the story "Fateful Day Slips Into Past?"
2. As a social worker assigned to evaluate this family, now that Ivie is returned home:
   a. Provide an assessment using the family health perspective.
   b. What goals and objectives, if any, would you recommend in working with this family?
   c. What ethical issues might be involved?
3. Which aspects of the social work curriculum would apply to issues in working with this family?

Key Terms

Child abuse
Domestic violence

Elder abuse
Family health perspective
Intimate partner violence
National Association of Social Workers' (NASW) Code of Ethics

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Introduction to Child Maltreatment

2

Frederick Mom Admits Abusing Child

A woman in Frederick, Maryland, has been sentenced to 15 years after she was found guilty of poisoning her own daughter. Thirty-three-year-old Wendi Scott pleaded guilty in March to first-degree child abuse for sickening her daughter to draw attention to herself, poisoning her with magnesium and using a syringe to remove blood. . . . Prosecutors had alleged that Scott's behavior was consistent with Munchausen syndrome by proxy, in which a caregiver fakes or induces illness in another to generate sympathy. (Leckie, 2008)

—Reprinted from the May 24, 2008, issue of *The Frederick News-Post* (MD).

Cruelties against children, such as the ones described in the story above, are difficult for most people to imagine. Yet, history is filled with stories of such abuse. Until relatively recently, no laws existed to place any restrictions on family relationships, and parents had the right to treat their children as they saw fit. Not until the beginning of the 20th century were any policies in place to protect children from parents who chose to mistreat them.

Thousands of social workers have dedicated their professional lives to the protection of children. They witness abused children as a daily part of their jobs. As a former Child Protective Services worker, the author can attest to the challenges these workers must overcome and the intrinsic rewards of their profession.

The profession of social work developed from the desire and determination of various individuals to help families who were unable or unwilling to provide for their children's basic needs. This chapter tracks the development of social service agencies particularly as applied to children. Because interventions provided by these agencies require a solid theoretical foundation to be effective, those that particularly apply to child maltreatment are reviewed. The definition of child abuse is clarified, and some controversies regarding this definition are considered. Also presented are explanations of various types of abuse and neglect as well as social policies that have been established to protect children. Chapters 3 through 6 build on this chapter by explaining more about Child Protective Services, the criminal justice system, and interventions on behalf of maltreated children.

The term *maltreatment* is used in this text as inclusive of child abuse and neglect. Differentiation of the term *family maltreatment* from *family violence* has been proposed (Levesque, 2001), with maltreatment meaning minimal physical endangerment and violence meaning serious physical endangerment. However, because the term *child maltreatment* is commonly used interchangeably with *child abuse* (Masten et al., 2008; Straus, 2000), no differentiation is made in this text. The intent of this author is not to challenge others' terminology but to simply clarify this issue for readers.

Theoretical Perspectives of Child Maltreatment

Because each child and family is unique, social workers are best equipped with several theories and their corresponding intervention strategies. Chapter 1 introduced the family health perspective and reviewed major micro-, mezzo-, and macrolevel theories commonly used by social workers as a basis for developing effective interventions for their clients. This chapter reviews theories that are particularly useful in explaining child maltreatment: biological, social–relational, neurobiological, psychodynamic, learning, and cognitive theories.

Biologically based theories, which address children's physical development, and social-relationally based theories, which address interactions between children and their parents, are highly useful for understanding and intervening in child abuse, particularly with young children. Among all maltreated children, infants and toddlers are most often abused. Boys and girls less than 1 year of age have a victimization rate of 22.2 and 21.5 per 1,000, respectively. For boys and girls of age 1, that rate drops to 13.2 and 12.7, respectively. The

rates continue to drop with nearly every increasing year of age (*Child Maltreatment,* 2007). The reason for this higher rate may be the total dependence of very young children on their parents and the demands they make on them.

Youngsters up to age 3 are totally dependent upon their caretakers; for the most part, they are unable to communicate verbally; and their world revolves around them and their caregivers. Out of frustration with their responsibilities, parents may spank them. The more fussy and unpredictable the infant, the more it tends to be spanked (Huang & Lee, 2008; Lahey et al., 2008). Infants who are spanked tend to develop challenging behavioral patterns that remain with them into later childhood, which then results in more corporal punishment (Zolotor, Theodore, Chang, Berkoff, & Runyon, 2008). Some researchers suggest that corporal punishment results in increased social and psychological problems for children later on (Straus & Donnelly, 2008). Biological and social-relational theories stress the importance of early prevention and intervention, especially on behalf of infants and toddlers. Early intervention can save the lives of these most vulnerable children and reduce problems as they mature.

Neurobiological theories focus on children's brain development as influenced by traumatic events, particularly child maltreatment (Donahue, 2000; Lee & Hoaken, 2007). The 1990s were known as the "Decade of the Brain" for all the extensive research that took place on this topic (Kendall-Tackett, 2000, p. 799). Children's brains hold 100 billion neurons, each releasing neurotransmitters, such as serotonin and dopamine, which are transferred from one neuron to another through the synapse gaps (Azmitia, 2001). Everything children see, hear, think, and touch transfers into an electrical activity that is stored into these synapses (Wasserman, 2007, p. 415).

The *plasticity* (malleability) of the brain provides certain windows of opportunity during children's cognitive development; these are specific times during which they are best able to learn certain tasks (Azmitia, 2001; Kendall-Tackett, 2000). The trauma of maltreatment results in "rewiring" of their brains and interferes with their normal cognitive, emotional, and social development. Because of the rapid development of the brain during children's first 5 years of life, they are particularly vulnerable during this period to the adverse **sequelae** (consequences) of abuse (Kentall-Tackett, 2000; Lee & Hoaken, 2007). The Adverse Childhood Experience (ACE) study reports that the sequelae of cumulative exposure to stressful events in childhood, including maltreatment, persist into adulthood, and that these include extensive health and social problems (Anda et al., 2006).

Also applicable to young children is the **attachment theory**, which stresses the importance of bonding between children and their parental figures (Bowlby, 1969). Numerous problematic behaviors of children and adults are attributed to inadequate or inappropriate attachment during their youth. Among these problems are the inability to feel empathy and to cope with life stressors as well as the development of *dissociation* (a disintegration of consciousness; Salmon, Skaife, & Rhodes, 2003) and related disorders. Left unresolved, disorganized attached behaviors can result in intergenerational transmission of violence; thus the child victim becomes the adult abuser (Bacon & Richardson, 2001). This theory, like most, stresses the necessity of early intervention in children's lives as the principal deterrent to future psychological and social problems not only for the victim but also for society overall.

Cognitive–behavioral theories often attribute child abuse to parents imitating the discipline they received as children (Cohen, Mannarino, Berliner, & Deblinger, 2000). These theories also relate to the **intergenerational transmission of violence,** where one generation teaches the next inappropriate behaviors. These theories focus on thoughts and behaviors learned from social experiences. By understanding people's perceptions of their reality, social workers provide therapeutic strategies to change irrational thinking and behaviors (Payne, 2005). Cognitive–behavioral therapies can be implemented with adults to help them change abusive behaviors learned from their own childhood.

All of these theories can be used in the early identification and treatment of child abuse. Infants and young children are particularly vulnerable to being abused and to the severity of damage when abused. Child abuse can be prevented through early learning as to the demands of parenthood and as to means of controlling inappropriate behaviors. Schools could have training programs; marriage license bureaus could require young adults applying for licenses to take training; and hospitals could offer training to parents before their babies are sent home with them. These are some ideas that require implementation, whether through governmental mandate or less formal policy making.

Brief Historical Time Line of Child Welfare Policies

Definition of "Childhood"

The view of childhood as a special time in individuals' lives is a relatively recent development. Historically, society considered children as chattel, at the mercy of their caregivers and beyond the interference of outsiders. Into the 15th century, the age of marriage was 12 for girls and 14 for boys, and girls as young as 5 were married to middle-age men. Children were sold for prostitution; and although incest and pedophilia were punishable by law, they were not uncommon (Lascaratos & Poulakou-Rebelakou, 2000).

In the mid-19th century, two major theories emerged that had a significant impact on the concept of "childhood" as a separate and important developmental time requiring particular attention and care. One of these theories, the theory of **evolution**—as established by Charles Darwin in *On the Origin of Species*, published in 1859—emphasized the role of "biological determinism" and highlighted the importance of genetics in the development of humans as well as other species.

The other theory, **psychoanalysis,** which was developed by Sigmund Freud in the late 1800s to early 1900s, emphasized the importance of childhood development, the role of "drives" in human behavior, and how early-life experiences can thwart "normal" development. Undergirded by theories such as evolution and psychoanalysis, the concept of childhood was formalized, and society began to recognize the need for a unique system of care for children in their preparation for adulthood (Kahan, 2006).

Care for Families and Children in Need

Into the 19th century, local American governments followed the English Poor Laws in dealing with people in poverty. Individuals who were unable to care for

themselves were treated as charity cases, undeserving of assistance. Homeless children were institutionalized in almshouses, where conditions were deplorably cruel (Hacsi, 1995; Kahan, 2006).

In 1851, adoption became legal with the passage of An Act to Provide for the Adoption of Children, and the "placing out" of homeless children with families other than their own began to replace institutionalization (Hacsi, 1995; Kahan, 2006). Charles Loring Brace, a minister, considered that his obligation was to help homeless children by placing them with families where they could be raised to be moral individuals. He believed that the fresh air of the West would be better for these children than the conditions of the slums in New York and other large cities (Cook, 1995; Kahan, 2006).

In 1854, Reverend Brace created the Children's Aid Society and began the "Orphan Trains," which transported poor homeless children from New York into the western parts of the country (Litzelfelner & Petr, 1997). Contrary to Brace's intentions, these children were often treated as new types of slaves.

Traveling on these "mercy trains," children were literally "put up" for adoption (Kahan, 2006, p. 55). At various stops, children stood on the train platforms and vied for the attention of the surrounding adults. Any adult could claim a child, and those who were not chosen boarded the train and traveled to the next station in hopes of finding someone to care for them. No authorities oversaw this process. Natural parents were not asked and adoptive families were not investigated. No one followed up on these children and their homes. Despite public outcry denouncing this process, the trains continued into the 1930s under the leadership of Brace's son (Kahan, 2006).

For indigent children who remained with their families, help was available from two sources—"friendly visitors" and Settlement House services—both of which formed the foundation of the social work profession. Associations of friendly visitors were formed by middle-class women, who voluntarily provided "outdoor relief" (another name for home-based assistance). The first friendly visitors learned through apprenticeship and had no formal training. Later, however, training became necessary to help them assume the organizational responsibilities that came with an increasing demand for services (Koerin, 2003).

To organize the friendly visitors and the growing number of charity groups, Charity Organization Societies (COS) arose throughout the country, the first being founded in Buffalo, New York, in 1877 (Brieland, 1995). The volunteers working in these organizations made formalized efforts to keep children in home-type settings. If parents were unable to provide for them, children were placed in other families' homes that were close to their natural parents' community rather than being sent far away where the parents had no opportunity to have them returned. Under the supervision of the COS, these placement homes were investigated for appropriateness and safety, thus providing the beginnings of the modern child welfare movement (Brieland, 1995).

In contrast to the service delivery of friendly visitors, settlement houses were formed based on the belief that the environment contributed to the conditions of families in poverty. Using Toynbee Hall (a famed settlement house in England) as a model, Jane Addams and Ellen Gates Starr opened the best-known settlement house in Chicago in 1889 (Brieland, 1995). Volunteer and paid workers believed that children's welfare could best be ensured in their natural caregivers' homes; thus they helped clients meet basic needs, including sanitation, housing, and day care. With the help of settlement house workers,

families were able to assist one another for their common needs and to improve the lives of their children. These workers lived in poor neighborhoods, along with the families that needed assistance. Settlement house workers became the first community planners, developers, and organizers who preceded modern-day social workers in community practice. The settlement house tradition—of concern for the individual and the environment—continues into the 21st century, delivering services, addressing unmet community needs, promoting social reforms, and linking needs to social policies (Koerin, 2003; Stuart, 1999).

In 1898, under the leadership of Mary Richmond of the Baltimore COS, the New York School of Philanthropy provided summer school training for individuals wanting to be friendly visitors; eventually this school would become known as the Columbia University School of Social Work (Brieland, 1995). By 1930, social work had become a legitimized profession and was taught in 34 universities throughout the nation. Professionally prepared social workers would soon be working with families and foster families for the improved care of children (Elliott & Leighninger, 2007).

In 1904, in recognition of the need for a more formalized system, Theodore Roosevelt convened the White House Conference on the Care of Children (Kahan, 2006). This conference resulted in the formation of the Children's Bureau in 1912, thus bringing the federal government into the lives of families and marking the "beginning of a child advocacy 'movement' in the United States" (Litzelfelner & Petr, 1997, p. 395). The Bureau was first led by Julia Lathrop, a social worker. With the philosophy of keeping children in their homes, funding was made available for mothers who had custody of their children but no economic means to support them. Social workers had the responsibility of determining which families were deserving of these funds (Kahan, 2006).

In 1935, Title IV of the Social Security Act, with its provision for Aid to Dependent Children, enabled children to remain in their homes despite lost income. Women who lost their husbands to death or divorce no longer had to bear the loss of their children (Hacsi, 1995). For families unable to care for their children, foster care programs became more formalized, and placing out children in homes outpaced placing them in institutions.

The Case of Mary Ellen and Modern Policies for Abused Children

The first modern-era case in which child abuse received legal recognition and prosecution occurred in 1874 in New York City on behalf of a 9-year-old named Mary Ellen Wilson (Jalongo, 2006). It is commonly reported that Mary Ellen could not be protected because no laws existed on behalf of abused children and that she was finally removed from an abusive household by use of the laws for Prevention of Cruelty to Animals. While these facts are mostly true, technically, Mary Ellen was protected with a writ of habeas corpus that enabled authorities to enter her guardian's home without permission (Jalongo, 2006). Most importantly, no laws were available to help Mary Ellen or any children who lived in abusive conditions at that time.

Mary Ellen Wilson's father had been killed in the Civil War, and her mother gave up custody. She was left under the guardianship of Thomas and Mary McCormack. Thomas McCormack falsely claimed to be Mary Ellen's father so that

she could live in his home. Thomas soon died, leaving only Mary McCormack as Mary Ellen's guardian (Jalongo, 2006).

Neighbors of Mary Ellen could hear, through the walls, the child's cries of pain. They contacted Etta Wheeler, a mission worker, who saw the child and became determined to remove her from her wretched conditions. The child was so underdeveloped that she appeared to be 5 rather than 9 years old. She wore only a summer dress even though the weather was cold. Bruises were evident on her body (Jalongo, 2006).

Etta Wheeler sought the help of Henry Bergh, a wealthy shipbuilder and influential man. Bergh was an ardent advocate for the protection of animals who, among other accomplishments, established the American Society for the Prevention of Cruelty to Animals (ASPCA) in 1866 (Jalongo, 2006). When Etta Wheeler approached Berg for help, he viewed Mary Ellen as "a little animal" needing protection (Jalongo, 2006, p. 2).

Bergh contacted an attorney, Elbridge T. Gerry, who later became the attorney for the ASPCA. Judge Lawrence of the New York Supreme Court approved a writ of habeas corpus authorizing the police to take Mary Ellen from her home. Mary Ellen was brought to the courthouse wrapped in a carriage blanket. Her body showed bruises evidently made with a braided leather whip. She had a gash through her eyebrow and down her cheek, which was inflicted with scissors by her guardian. The sight of this child made men weep out loud. With further pleas from Etta Wheeler, Henry Bergh continued his acts of benevolence and established the Society for the Prevention of Cruelty to Children to protect future children from abusive situations (Jalongo, 2006).

The life of Mary Ellen after this incident is seldom reported. With the help of Etta Wheeler and Henry Bergh, she was adopted by relatives of Mrs. Wheeler. As an adult, she married and, later, had three children and several grandchildren. She died at 92 years of age in 1956 (Jalongo, 2006).

In the mid-1900s, advances in medical technology helped medical professionals begin to notice, report, and classify the physical symptoms of child abuse. John Caffey, a physician, performed radiologic examinations on children; in 1946 he reported in the *Journal of Roentgenology* on six cases of children who had subdural hematomas and other injuries that were similar in nature and that were probably inflicted by adults, as they seemed otherwise inexplicable (Linsey, 1994). In 1955, Paul Woolley and William Evans, two other physicians, reported in the *Journal of the American Medical Association* (JAMA) on 12 infants who had physical injuries that could not be explained except as having been inflicted by an adult (Linsey, 1994).

In 1962, C. H. Kemp and his physician colleagues published an article in JAMA that proposed a definition and diagnosis of battered child syndrome. The article was based on 302 children who had physical injuries that could not be explained except as the result of abuse (Linsey, 1994). The diagnosis of **battered child syndrome** applied to any child suffering, over a period of time, certain types of injuries not caused by accidental means; children under 3 years of age were particularly prone to receive this diagnosis (Hacsi, 1995).

The Child Abuse Prevention and Treatment Act (CAPTA)

In 1974—100 years after Mary Ellen's groundbreaking case—the federal government enacted the **Child Abuse Prevention and Treatment Act** (CAPTA).

CAPTA defined child abuse and neglect and established mandatory reporting policies. It provided federal funding to states to support prevention, assessment, investigation, prosecution, and treatment on behalf of abused and neglected children (About CAPTA, n.d.; Herman, 2007). It also included support for research, evaluation, technical assistance, and data collection. In 2002, for example, $22 million CAPTA-related grants were awarded for prevention and treatment, program development, and data collection (Child Abuse Prevention and Treatment Act, n.d.).

CAPTA established the Office of Child Abuse and Neglect and the National Clearinghouse on Child Abuse and Neglect Information, which in 2006 became the Child Welfare Information Gateway. The Child Welfare Information Gateway functions under the auspices of (in descending order) the (a) U.S. Department of Health and Human Services; (b) Administration for Children and Families; (c) Administration on Children, Youth and Families; (d) Children's Bureau; and (e) Office on Child Abuse and Neglect. Among its many resources, it offers a *User Manual Series* on child abuse and neglect. The Child Welfare Information Gateway's resources can be obtained through its website (www.childwelfare.gov).

The National Child Abuse and Neglect Data System (NCANDS) is funded under CAPTA. Using State Child Protective Services (CPS) data, NCANDS annually publishes the *Child Maltreatment Report* (National Child Abuse and Neglect Data System, 2006). Each state is mandated to provide data on the number and sources of child abuse and neglect reports, investigation dispositions, types of maltreatment, and related information.

CAPTA also provided for the reporting of the *Fourth National Incidence Study of Child Abuse and Neglect* (2008), which includes data from more than 5,600 community professionals having contact with maltreated children. Data from NIS does not duplicate NCANDS but adds data from sources not reported to CPS.

Other Child Welfare Agencies

The U.S. Department of Health and Human Services is the federal agency responsible for the health, safety, and well-being of America's citizens. Under this department, the Administration of Children, Youth and Families (ACYF) is responsible for the major federal programs that support social services for children and youth, protective services for children and youth, child care, and adoption (Welcome to ACYF, n.d.). Created in 1912, the Children's Bureau (CB) is the oldest federal agency for children within ACYF (Rosenthal, 2000). As one of six bureaus within ACYF, the CB is responsible for administering federal child welfare programs that provide for the safety, permanency, and well-being of children (About the Children's Bureau, n.d.; Herman, 2007).

Various private organizations also provide research, advocacy, and training on behalf of children's welfare. They include the Child Welfare League of America (www.cwla.org), Children's Defense Fund (www.childrensdefense.org), and the Annie E. Casey Foundation (www.aecf.org) (Litzelfelner & Petr, 1997).

Other Policies That Affect Child Welfare

Since their inceptions, many amendments to CAPTA and to the Social Security Act of 1935 have been passed to improve services on behalf of abused and neglected children. Among them are the following (About CAPTA, n.d.; Child Abuse Prevention and Treatment Act, n.d.; Compilation of the Social Security Laws, n.d.; Herman, 2007; Kaushal, Gao, & Waldfogel, 2007; Rosenthal, 2000):

1. *Title-IV-B of the Social Security Act*: Provides support for the initial investigation and law enforcement services to prevent family breakup, reunify children, and place children when reunification is not possible.
2. *1967 Amendment to the Social Security Act*: Authorized purchase of service from voluntary agencies, which resulted in child welfare agencies being available throughout the country; this eventually led to "public/private partnership"—also known as "privatization" (Rosenthal, 2000, p. 282).
3. *Personal Responsibility and Work Opportunity Reconciliation Act of 1992* (P.L. 104-193): Changed welfare reform as it had been known, shifting "the focus of U.S. welfare policy from providing cash benefits for low-income single mothers to providing work incentives and a range of supports for the working poor" (Kaushal et al., 2007, p. 371); this act would change family dynamics of low-income single mothers who already had the responsibility of child care.
4. *Title-IV-E of the Social Security Act:* Provides for the Federal Foster Care and Adoption Assistance Program to partially reimburse costs of caring for children removed from their homes.
5. *Adoption and Safe Families Act of 1997* (P.L. 105-89): Seeks to promote the safety, permanency, and well-being of children in foster care; accelerate the permanent placement of children in care; and increase the accountability of the child welfare system.
6. *Child Abuse Prevention and Enforcement Act* (P.L. 106-177): Seeks to reduce the incidence of child abuse and neglect through law enforcement initiatives and prevention activities.
7. *Foster Care Independence Act* (P.L.106-169): Amends Title IV-E of the Social Security Act to provide States with more funding and greater flexibility in carrying out programs designed to help children make the transition from foster care to self-sufficiency.
8. *PROTECT Act (Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act of 2003*; P.L. 108-21): Creates a national Amber Alert system and enhances penalties for child sexual abuse, sexual exploitation, and child pornography.
9. *Promoting Safe and Stable Families Amendments of 2001* (P.L. 107-133): Extends and amends the Promoting Safe and Stable Families program; amends the Foster Care Independent Living program.
10. *Keeping Children and Families Safe Act of 2003* (P.L. 108-36): Amends CAPTA to require criminal background checks for foster and adoptive parents and provides resources for placing older children in adoptive families.
11. *Adoption Promotion Act of 2003* (P.L. 108-145): Reauthorizes the adoption incentive program under Title IV-E; provides additional incentives for adoption of older children (age 9 and older) from foster care.

12. *2003 Amendments to the Child Abuse Prevention and Treatment Act:* Amends CAPTA to require "child welfare programs to refer all child victims of abuse and neglect younger than three to local early childhood intervention programs" (Herman, 2007, p. 17).

Definitions and Types of Child Maltreatment

The following sections address the definition and types of child abuse and neglect. What seems to be an easy issue to address is actually a complex one. Social workers are mandated to report child maltreatment. So what is this maltreatment that is to be reported? If, in a grocery store, a 2-year-old child is spanked, is that abuse? If, in a grocery store, a belt is taken to a 7-year-old child, is that abuse? Although defined in the statutes, differentiating child discipline from child abuse remains a contentious issue.

The Child Abuse Prevention and Treatment Act (n.d.) defines "children" as persons under the age of 18 except in cases of sexual abuse. For sexual abuse, the age is specified by state statutes. A "caregiver" is any person responsible for the child's welfare, including adults in residential care, out-of-home care, and day-care facilities. Maltreatment of a child includes circumstances that harm a child's health or welfare as well as circumstances that threaten to be harmful to the child.

According to CAPTA as amended by the Keeping Children and Families Safe Act of 2003, child abuse and neglect is defined as:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation
- An act or failure to act which presents an imminent risk of serious harm (Child Maltreatment, 2006, p. xiii)

Minimum standards for defining child abuse are set forth within CAPTA, which categorizes various acts of maltreatment under four broad types: (a) physical abuse; (b) sexual abuse; (c) emotional abuse; and (d) neglect. All states, U.S. territories, and the District of Columbia must meet the basic minimum standards in defining abuse; however, these definitions vary depending on the statutes of the specific location (e.g., state statutes; Definitions of Child Abuse and Neglect, 2007; Massey-Stokes & Lanning, 2004). Some states and territories use a single concept for abuse and neglect while others provide separate definitions depending on the specific act. Only some of these definitions include child exploitation (other than sexual), which is the use of children for labor and/or the withholding of medically prescribed treatment for an infant's life-threatening conditions. Various communities, agencies, and military personnel can use their own criteria for child maltreatment. The principal stipulation for child-maltreatment criteria is that they meet the minimum standards set forth by the federal and state governments (Definitions of Child Abuse and Neglect, 2007).

Appendix A offers a listing of telephone numbers and websites for Child Protective Services in every state. Further clarification as to the legal defini-

tions and statutes for each state can be obtained using this resource. The Child Welfare Information Gateway also provides information on various child welfare issues, searchable by state (see http://www.childwelfare.gov/systemwide/laws_policies/state/).

Although definitions differ among states, the following provides some specific acts that tend to be considered abusive under the standard criteria of the four groupings set forth by CAPTA: (a) physical abuse, (b) sexual abuse, (c) emotional abuse, and (d) neglect.

Physical Abuse

Physical abuse is the nonaccidental infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or otherwise harming a child (Definitions of Child Abuse and Neglect, 2007). The abuse may result from one-time or many incidents. "Nonaccidental" abuse to a child is harm inflicted as a result of discipline, even if the adult did not "intend" to harm the child. Unintentional abusive acts do not result from accidents; unintentional abuse is doing harm to the child by using inappropriate discipline or, in some cases, corporal punishment. Physical abuse, especially unintentional, often occurs when the adult is angry and strikes, shakes, or throws a child. Spanking and other types of corporal punishment are especially harmful to children under 3 years of age (Zolotor et al., 2008). Physical abuse includes the following acts (Child abuse, n.d.):

- Beating, whipping, paddling, punching, or hitting
- Pushing, shoving, shaking, kicking, or throwing
- Biting, choking, or hair pulling
- Burning with cigarettes, water, or other hot objects
- Inflicting severe physical punishment

The issue of spanking as a form of discipline requires special discussion. No law considers spanking within "reasonable" limits as child abuse unless the spanking leaves bruises and marks. However, the act of spanking is an issue of considerable research and controversy. Straus and Donnelly (2008) refer to spanking as synonymous with hitting, physical attack, and physical assault. Other researchers suggest that even if spanking does not result in serious physical harm, it often results in severe psychological harm, other forms of family violence, and intergenerational violence (Whitney, Tajima, Herrenkohl, & Huang, 2006).

Various types of discipline, including spanking, require definition as whether they should be classified as abusive (Runyan et al., 2005). Various factors tend to be taken into consideration in categorizing acts as abusive, including the age of the child, developmental level of the child, severity of the abuse, frequency of abuse, and "contextual" (historical or cultural) perspectives of the family and community (Korbin, Coulton, Lindstrom-Ufuti, & Spilsbury, 2000; Runyan et al. 2005). Indeed, the definition of child maltreatment tends to be "fluid" (Whitney et al., 2006, p. 338) and in need of more specificity for social workers, children, and parents (Bensley et al., 2004; Whipple & Richey, 1997).

Sexual Abuse and Exploitation

Sexual abuse includes a range of acts performed either directly on the child or in the presence of a child, including (Child abuse, n.d., paragraph 6):

- Fondling, touching, or kissing a child's genitals
- Making the child fondle the adult's genitals
- Penetration, intercourse, incest, rape, oral sex, or sodomy
- Exposing the child to adult sexuality in other forms (showing sex organs, forcing observation of sexual acts, showing pornographic material, telling inappropriate jokes)
- Other privacy violations (e.g., forcing the child to undress, spying on a child)
- Sexual exploitation
- Enticing the child to pornographic sites or other material on the Internet
- Luring the child through the Internet for sexual meetings
- Exposing the child to pornographic movies or magazines
- Child prostitution
- Using a child in the production of pornography

The abusers can be parents, siblings, relatives, child-care workers, clergy, teachers, coaches, neighbors, friends, or strangers. The abuser may be younger than 18 years of age—often a sibling, cousin, or peer (Alpert, 1997). The act of abuse is determined by the power differential between the child and the perpetrator. The child does not need to react in a certain manner for the act to be inappropriate; a child's reaction does not excuse a perpetrator's action.

Emotional Abuse

Emotional abuse is any attitude or behavior, as well as omission of attitudes and behaviors, by the caregiver that interferes with the child's behavioral, cognitive, emotional, or mental well-being. These attitudes and behaviors include verbal abuse, mental abuse, and psychological maltreatment. Emotional abuse is increasingly associated with the witnessing of domestic violence (Jellen, McCarroll, & Thayer, 2001). Emotional abuse is present whenever any other type of abuse occurs and involves the following (Child abuse, n.d., paragraph 6; Jellen et al. 2001):

- Ignoring, withdrawal of attention, or rejection
- Lack of physical affection
- Lack of praise or positive reinforcement
- Yelling or screaming
- Threatening or frightening
- Negative comparison to others
- Belittling, telling the child she or he is "worthless" or "bad"
- Using derogatory terms to describe the child (name calling)
- Shaming or humiliating
- Habitual scapegoating or blaming
- Using extreme or bizarre forms of punishment such as confinement to a closet, tying to a chair, or terrorizing
- Parental child abduction

Neglect

Child neglect is failing to provide for a child's basic needs, including physical, educational, emotional needs, or medical care. Neglect tends to be chronic, while physical abuse tends to be episodic. Neglectful behaviors can be categorized as cognitive, emotional, physical, or supervisory; severe neglect can result in the death of a child (Straus, 2006). Neglect includes:

- Inadequate or inappropriate provision of food, housing, or clothing
- Lack of supervision
- Expulsion from the home
- Refusing to allow a runaway child to return home
- Allowing school truancy
- Abandonment
- Denial or delay of medical care
- Inadequate hygiene
- Domestic violence in the home
- Drug and alcohol abuse in the presence of the child

Other Forms of Abuse

Sibling abuse: The commission of an act by a sibling causing physical harm, injury, or death to a brother or sister (Caffaro & Conn-Caffaro, 1998). Sexual abuse of a sibling is a common type of abuse. Sexual abuse is difficult to distinguish from sexual play; however, abuse tends to be exploitive in nature (Alpert, 1997).

Munchausen by proxy syndrome: The intentional simulation of physical disease by the parents in their child for the sole purpose of obtaining medical or psychological attention (Parnell, 1998). Even older children, well into their teens, may be coerced to collude with their parent, thus undergoing unnecessary medical tests and continued parental abuse (Awadallah et al., 2005).

Nonorganic failure to thrive (FTT): The child's inadequate and potentially life-endangering physical development having no organic basis. Nonorganic FTT can coexist with child maltreatment. Either of these conditions can result in adverse behavioral and developmental outcomes; together these conditions place children at greater risk for negative consequences (Kerr, Black, & Krishnakumar, 2000).

Substance abuse: The caregiver's manufacturing of a controlled substance in the presence of a child or on premises occupied by a child, allowing the child to be present where chemicals are stored, using a controlled substance that impairs the caregiver's ability to care for the child, exposing the child to drug paraphernalia, or selling or giving the child drugs (Definitions of Child Abuse and Neglect, 2007).

Polyvictimization: Refers to children who suffer from more than one type of abuse described above (Finkelhor, Ormrod, & Turner, 2007).

Prevalence of Child Maltreatment

Two notable national studies of child abuse include the First National Family Violence Survey, which was reported in 1980 by Straus, Gelles, and Steinmetz,

using data collected in 1975, and the Second National Family Violence Survey (see Wolfner & Gelles, 1993), using data collected in 1985. Both studies gathered data using the Conflict Tactics Scale (CTS) with additional questions. The CTS "measures three categories of tactics used in interpersonal conflict within the family: reasoning, verbal aggression, and physical aggression" (Wolfner & Gelles, 1993, p. 197). The 1975 survey collected data via in-person interviews; whereas, the 1985 survey utilized telephone interviews. Surveys such as these are paramount in bringing the seriousness of child abuse to the awareness of the American public (Wolfner & Gelles, 1993).

Currently, at least a dozen major child maltreatment data collection systems exist (Finkelhor & Wells, 2003). For example, statistics on child abuse and neglect are released in the annual *Child Maltreatment Report* (2007) sponsored by the National Child Abuse and Neglect Reporting System (NCANDS). These reports have been available since 1990 and were stipulated in the 1988 CAPTA directive. Data are gathered from Child Protective Services (CPS) agencies throughout the country. As of this writing, the latest edition available was the 2007 report, which included the following statistics (*Child Maltreatment Report,* 2007):

- Approximately 3.2 million referrals, involving alleged maltreatment of approximately 5.8 million children, were made to CPS.
- Of those, approximately 62% were screened in for investigation or assessment by CPS agencies.
- Approximately 25% of the investigations determined at least one child who was found to be a victim of abuse or neglect.
- More than half (57.7%) of the reports were made by professionals.
- An estimated 794,000 children were determined to be victims of abuse or neglect.
- The youngest children had the highest rates of victimization. Nearly 32% of all victims were younger than 4 years old; 23.8% were 4 to 7 years and 19% were 8 to 11 years of age.
- Victims suffered the following types of abuse:
  - 59.0% of victims experienced neglect.
  - 10.8% were physically abused.
  - 7.6% were sexually abused.
  - 4.2% were psychologically maltreated.
  - 13.1% were victims of multiple maltreatments.
- Approximately 1,586 children died because of child abuse or neglect; nearly 76% were less than 4 years old.
- In the fatalities, nearly 70% of the perpetrators were one or more parents.

Another major report on child maltreatment is the *Fourth National Incidence Study of Child Abuse and Neglect*, which is also mandated under CAPTA. To date, the U.S. Department of Health and Human Services (DHHS) has mandated four national incidence studies, the most recent of which is under way.

NIS data are gathered from agencies required to investigate child abuse and from other professionals having knowledge of incidences. Data are categorized in such a way as not to be duplicative and are classified by two sets of standards:

- The "Harm Standard," the more stringent of the two, reports data from acts or omission of acts resulting in "demonstrable harm" to children.
- The "Endangerment Standard," the more lenient one, reports data from acts to children who, although not yet harmed, are in danger of being harmed.

The following are some data from the NIS-3 (which was published in 1996) as compared to NIS-2 (1986) (Sedlak & Broadhurst, 1996):

Child Abuse and Neglect

- The estimated number of sexually abused children under the harm standard rose from 119,200 in 1986 to 217,700 in 1993 (an 83% increase).
- The number of physically neglected children under the harm standard increased from an estimated 167,800 to an estimated 338,900 (a 102% increase).
- There was a 333% increase in the estimated number of emotionally neglected children using the harm standard, from 49,200 in the NIS-2 to 212,800 in the NIS-3.
- The estimated number of physically abused children under the harm standard was 269,700 at the time of the NIS-2, but it had increased to 381,700 during the NIS-3 (a 42% increase).

Child Characteristics

- Girls were sexually abused about three times more frequently than boys.
- Boys were at somewhat greater risk of serious injury (24% higher than girls' risk under both definitional standards), and boys were significantly more likely to be emotionally neglected (boys' risk was 18% greater than girls').
- No racial differences were noted in the study.

Family Characteristics

- Children of single parents were at higher risk of physical abuse and of all types of neglect. Specifically, as compared with children in two-parent families, children in single parent families faced:
  - 77% greater risk of physical abuse
  - 87% greater risk of physical neglect
  - 74% greater risk of emotional neglect
  - 80% greater risk of serious injury
  - 90% greater risk of moderate injury
- The incidence of maltreatment was related to the number of dependent children in the family. Children in the largest families (four or more children) were physically neglected at nearly three times the rate of those who came from one-child families.
- Family income was significant in nearly every category of maltreatment. Compared to children whose families earned $30,000 per year or more, those in families with annual incomes below $15,000 per year were:

- More than 22 times more likely to experience some form of maltreatment under the harm standard and over 25 times more likely to suffer maltreatment of some type using the endangerment standard
- More than 44 times more likely to be neglected by either definitional standard
- Almost 18 times more likely to be sexually abused by either definitional standard
- Over 22 times more likely to be seriously injured by maltreatment under either standard

Among the conclusions from the NIS report is the greater risk for maltreatment of children living in larger single-parent and low-income families. The youngest of our citizens (children ages 4 and under) are at highest risk of abuse. Poverty is one of the greatest contributors for child abuse and neglect.

According to the NCANDS data system, child maltreatment rates declined 23% from 1992 to 2003 (Jones, Finkelhor, & Halter, 2006). The causes for these declines are unclear and have been attributed to several issues: flaws in the data collection system (Finkelhor & Wells, 2003), the country's economic improvement during that period, increased incarceration of individuals committing crimes against children, and greater use of psychiatric medication to control behaviors (Jones, Finkelhor, & Halter, 2006).

The reader may find the rationale of economic improvement for the decline of child abuse to be disconcerting, considering the state of the world's economy at the time of the writing of this volume. If fair economic times led to reduced child abuse, the rates of abuse can be anticipated to rise during economic downturns. Only time will tell the story as to the resilience of families in the face of hardships as they relate to one another within their homes.

Summary

This chapter presents various theories that are particularly related to the dynamics of child abuse and neglect. The biological and social–relational theories are based on children's vulnerability and dependence on adults for their care. The neurobiological theories, which bring attention to children's brain development and functioning, are an integral part of the study of the effects of child abuse and neglect. The importance of children's attachment and bonding to an important caregiver has long been known and cannot be underrated for the development of physically and emotionally healthy children. Cognitive–behavioral theories stress the imitative behaviors of adults in raising their children as they were raised. Theories that help explain the actions of adults toward children provide further evidence of the need for prevention and early intervention strategies for making significant strides in the reduction of child mistreatment by their caregivers.

The concept of childhood as a special developmental period in life is a relatively new creation of postmodern society. In previous eras, children were considered chattel and at the mercy of their caregivers. Darwin's and Freud's theories contributed to an emphasis on early development and are among the paradigm shift that raised people's awareness of childhood as different from adulthood.

At the same time, medical science and industrialization combined to make public new developments, such as Kemp's diagnosis of the battered child syn-

drome. The first federal legislation, the Child Abuse Prevention and Treatment Act (CAPTA), was passed only 30 years ago, during the 1970s. CAPTA categorizes **child maltreatment** as physical abuse, sexual abuse, emotional abuse, or neglect. Abusive and neglectful acts come in many forms, including sibling abuse, Munchausen by proxy syndrome, nonorganic failure to thrive, and polyvictimization.

The U.S. Department of Health and Human Services is the principal federal agency charged with the protection of citizens. Under this department, the Administration of Children, Youth and Families (ACYF) and the Children's Bureau (CB) are established for administering child welfare programs. Under this agency's purview, CAPTA (n.d.) was passed and continues to be amended for improved child protection and caregiver education, including the information provided through the National Child Abuse and Neglect Data System (NCANDS), the National Incidence Study of Child Abuse and Neglect (NIS), and the Child Welfare Information Gateway.

This chapter provides a basis for further study and understanding of child abuse and neglect by offering an introduction to theoretical underpinnings, an historical view of childhood, major events leading to society's awareness of the need to protect children, and an explanation of the various types of maltreatment. Legislative bodies, policies, and agencies are in place to assist in this protection. Some decline in abuse may have resulted from changes in societal norms, decreases in poverty, improved agents of social intervention, and criminal prosecution of abusers. Social workers, other health care professionals, and laypersons have the responsibility of not only understanding the past but also making changes for a better future.

Mother of Starved Baby Pleads Guilty

Eight-month-old Jeremiah Nelson weighed just eight pounds when he died on Dec. 15, 2005, at the home he shared with his mother and four siblings on Courtyard Place in north St. Louis County.

Jeremiah died of malnutrition and starvation, the county's chief medical examiner, Dr. Mary Case, would have testified this week in the trial of the baby's mother, Qudsia Owens.

But there was no trial.

Instead, Owens, 25, decided to plead guilty on Monday in St. Louis County Circuit Court of second-degree murder and five counts of endangering the welfare of a child. Each endangering count is a reference to one of her children.

Owens will be sentenced next month and could receive life in prison.

Defense attorney Philip Dennis and prosecutor John Quarenghi were unable to reach an agreement on punishment, so Circuit Judge Richard Bresnahan will decide her fate. He has ordered a pre-sentence report from the state Board of Probation and Parole.

Dennis said he would ask for leniency and the minimum sentence of 10 years in prison. He said Owens has already served two years in jail and has been "consumed with guilt since the beginning of the case."

(continued)

Jeremiah was born prematurely and had been hospitalized at birth for a month.

Case would have been a key witness at a trial, Quarenghi said. Other witnesses would have included a neighbor and a teacher, who would have testified that a sister, 5, often complained of being hungry.

Also scheduled to testify were Police Officer Mike Otten, the first officer at the scene; Detective David Kopfensteiner, the lead investigator; and Luzette Wood, then a forensic interviewer and child abuse specialist. The three testified at a hearing in July of last year to revoke Owens' probation in a prior robbery case.

Otten said paramedics thought the victim was so emaciated that he appeared to be 2 months old rather than 8 months. In the refrigerator that day, Otten found a bottle of baby formula and a bottle of vodka—nothing else.

Kopfensteiner said Owens admitted to him she had left the children alone on days she worked.

Wood interviewed three of the children, who were 8, 7, 5, and 2. The 8-year-old, a boy, was supposed to be in charge when his mother was away.

Dennis said a psychiatric evaluation found Owens competent to stand trial and determined she was in control of her actions at the time Jeremiah died. Dennis questioned some of the conclusions, noting that the report made no mention of the five months Qudsia Owens spent in a mental ward during her adolescence.

Dennis said also that another woman had been living in the house and was supposed to care for the children in Owens' absence. That individual has not been charged.

Dennis said he had been prepared to go to trial but the defendant decided to plead guilty.

Quarenghi said he had planned to counter defense arguments about household poverty with bills from a cable television company showing that Owens not only had cable television "but all the bells and whistles" such as extended service and premium stations.

Owens' probation was revoked last year and she is serving a 12-year sentence for a robbery she committed under the name of Lynne Brown in 2002. (Lhotka, 2007)

—Reprinted from the December 13, 2007 issue of the *Springfield News-Leader* (MO).

Discussion Questions

1. Apply the various theories presented in this chapter to the case of Jeremiah Nelson. Which theories do you think most accurately explain the abuse of the children in this case?

(continued)

2. Having reviewed the various types of abuse and neglect, what types of maltreatment did Jeremiah and his siblings experience?
3. What policies are needed to help prevent this type of tragedy? What is your opinion as to the legal consequences for the mother in this case?
4. Imagine you are the social worker assigned to conduct the presentence report to the judge. What type of information would you gather and from whom?

Key Terms

Attachment theory
Battered child syndrome
Biologically based theories
Child Abuse Prevention and Treatment Act (CAPTA)
Child maltreatment
Cognitive–behavioral theories
Evolution
Intergenerational transmission of violence
Munchausen by proxy syndrome
Neurobiological theories
Nonorganic failure to thrive
Polyvictimization
Psychoanalysis
Sequelae
Sibling abuse

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Identifying and Investigating Child Maltreatment

3

Father of Baby Hit by Pellets Gets 12 Years

Shawn Michael Mohan kept saying his 12-day-old son's pellet-gun wounds were accidental, perhaps affecting a prison sentence that a judge in St. Charles County gave him Friday.

Before sentencing Mohan to 12 years, Circuit Judge Lucy Rauch said she had to look at whether Mohan was likely to reoffend. "One of the most difficult aspects of this job is to predict future behavior," she said.

She said Mohan's story—that an air gun rigged to fire several plastic pellets at once fired accidentally—didn't make sense. She said Mohan had tried to minimize what he had done. "We have a history here of explanations that strain credibility," she said.

(continued)

Mohan, 20, was accused of shooting his son several times with a pellet gun on Dec. 21. The baby's injuries were inflicted in Mohan's apartment in an unincorporated part of St. Charles County. Mohan told police and the court that the gun had fallen and fired accidentally.

Assistant Prosecutor Philip Groenweghe argued for the maximum sentence of 15 years, presenting photographs of the baby's wounds. One by one, he described wounds in the cheek, arm, foot, hand, and buttocks, each one described as centered.

Rauch later said the wounds' symmetry made the accidental shooting story more unlikely.

Groenweghe also said Mohan already was on probation in another child endangerment case and kept refusing to accept responsibility. "He's already abused two children," Groenweghe said. "He should not have an opportunity to abuse a third."

Paul Kaiser, Mohan's attorney, said the baby suffered only bruises from the incident and won't remember them later in life. Meanwhile, he said, his client's picture appeared in newspaper pages, sensationalizing the case. He said people who commit armed robbery and manslaughter receive lesser sentences than what prosecutors were recommending.

Prosecutors had offered Mohan a recommendation for a 13-year sentence in exchange for his guilty plea. He rejected the offer.

Mohan wrote a statement, which he rose to read before his sentencing. He exhaled heavily but appeared to be too overcome by emotion to read the statement. Kaiser read it for him.

He said his actions were "irresponsible and negligent."

The child's mother sat with Mohan's family directly behind him. They declined to comment.

Mohan is to serve the 12-year sentence concurrently with a four-year term for the probation revocation. (Anthony, 2007)

—Reprinted from the July 21, 2007 issue of the *St. Louis Post-Dispatch* (MO).

Shawn Michael Mohan's case describes some of the complexities in determining whether abuse has occurred. This chapter addresses the identification, reporting, and investigation of suspected child maltreatment.

Identifying Child Maltreatment

A large percentage of professionals fail to report cases of child abuse and neglect (CAN), partly because they lack confidence in their ability to identify maltreatment (Delaronde, King, Bendel, & Reece, 2000; Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000). Familiarity with risk factors and maltreatment indicators can increase the comfort level for reporters. **Risk factors** include financial stress, family structural stressors, and child development issues. These factors are correlated with the stress of caring for a child and thus the potential abuse of that child (Bolen, McWey, & Schlee, 2008; Connell-Carrick,

2003). (Note that throughout this and other chapters, the term *parent* is typically used to describe the primary caregiver for a child. In actuality, the parental role may be held by guardians, stepparents, grandparents, foster parents, or other primary caregivers.)

Various family and parental characteristics place children, particularly preschoolers, at risk for maltreatment. Poverty is the most prominent factor, particularly for families earning $15,000 or less annually. This probability is increased in families with young mothers (i.e., 17 years of age and younger), one-parent families, and large families (five or more members; Bolen et al., 2008; Connell-Carrick, 2003).

Factors that increase the risk of child maltreatment include a low educational level, substance abuse, and lack of a support system. Maltreating parents often have poor parenting skills as well as unrealistic expectations of child development. They expect their children to be able to control their bodily functions, maintain self-discipline, and complete tasks that are beyond the child's physical, cognitive, and/or emotional capabilities (Bolen et al., 2008). In many cases, these parents were abused as children themselves (Connell-Carrick, 2003). Often, abusive parents consider their children unworthy, unappreciative, barriers to their own happiness, or reminders of a former abusive spouse (Bolen et al., 2008; Connell-Carrick, 2003).

Indicators of child maltreatment include symptoms of potentially abusive and neglectful behaviors. As a guide, a list of potential indicators is provided below, according to the four types of **child maltreatment**—physical abuse, sexual abuse, emotional abuse, and neglect. They are categorized by appearance and behaviors of the child and the parents; many indicators are dependent upon the child's age.

Signs of Potential Physical Abuse

The following lists are adapted from Kairys and Alexander (1999); Mulryan, Cathers, and Fagin (2004); and Powell (2003).

Physical Signs

- Unexplained bruises, broken bones, or black eyes
- Multiple unexplained bruises in various stages of healing
- Head injuries
- Injuries in particular locations (buttocks, thighs, genitalia, neck, cheek, ear)
- Certain types of fractures, particularly spiral
- Bilateral black eyes
- Imprint burns (as from an iron or cigarette tip)
- Immersion burns not consistent with accidents (such as contour demarcations from burns resulting from immersion in hot water)
- Human bite marks
- Lacerations of the tongue
- Fractured or displaced teeth
- Facial bone and jaw fractures
- Scarring at corners of mouth (may indicate the use of gags)

Child Behaviors

- Frightened of parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Apprehensive when other children cry
- Reports injury by a parent or another adult caregiver
- Cruelty to animals
- Aggressive to peers
- Has eating disorders
- Encoporesis (soiling)
- Head banging/rocking
- Sudden changes in behaviors
- Antisocial behaviors

Parent/Guardian Behaviors

- Offers conflicting, unconvincing, or no explanation for the child's injury
- Unconcerned about the child
- Describes the child in negative ways
- Uses harsh physical discipline with the child
- Has psychopathic or psychotic disorder
- Has history of abuse as a child
- Substance abuse
- Unrealistic expectations of child
- Unintended pregnancy

Signs of Potential Sexual Abuse

The following lists are adapted from Alter (2001); Brown, Brack, and Mullis (2008); Dubowitz, Black, and Harrington (1992); Peters (2001); and Paolucci, Genius, and Violato (2001).

Physical Signs

- Difficulty walking or sitting
- Vaginal or anal injuries
- Genital pain, adhesions, discharge, or scarring
- Sexually transmitted infection or pregnancy, particularly if under age 14

Child Behaviors

- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Talks with other children about sexual acts
- Reports sexual abuse by a parent or another adult caregiver
- Reluctance to undress
- Has nightmares
- Shows change in sleeping or eating patterns
- Has low self-esteem
- Is depressed
- Shows inappropriate or sudden change in affect (sad, angry, anxious, or flat)

- Shows symptoms of posttraumatic stress disorder
- Has poor peer relationships
- Repeatedly runs away
- Is promiscuous
- Engages in self-injurious behaviors (cutting, burning, head-banging)
- Engages in prostitution
- Engages in criminal behavior

Parent/Guardian Behaviors

- Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
- Is secretive and isolated
- Is frequently absent from the home
- Is jealous or controlling with family members
- Was sexually abused as child

Signs of Potential Emotional Abuse

The following lists are adapted from Jellen, McCarroll, and Thayer (2001) and Mulryan and colleagues (2004).

Child Behaviors

- Shows extremes in behavior, such as overly compliant or demanding behaviors
- Shows inappropriately adult (parenting other children) or infantile (tics) behaviors
- Has nervous habits (nail biting or thumb sucking)
- Has conduct disorders
- Exhibits delayed physical or emotional development
- Reacts oddly to persons in authority
- Is suicidal
- Reports a lack of attachment to the parent
- Has frequent trips to hospital with no findings of diagnosed problems
- Has low self-esteem
- Is isolated
- Is unable to learn
- Is unable to build or maintain satisfactory interpersonal relationships
- Evinces a pervasive mood of unhappiness or depression
- Has memory distortions
- Is often irritable and angry

Parent/Guardian Behaviors

- Constantly blames, belittles, or berates the child
- Is unconcerned about the child and refuses to consider offers of help for the child's problems
- Overtly rejects the child
- Withholds love
- Rejects the child

- Terrorizes the child
- Verbally lashes out at the child
- Yells at the child
- Blames the child for things he or she did not do

Signs of Potential Neglect

The following lists are adapted from Kairys and Alexander (1999) and Mulryan and colleagues (2004).

Physical Signs

- Has severe, persistent diaper rash
- Exhibits failure to thrive (infants)
- Has extreme physical or cognitive developmental delays
- Lacks needed medical or dental care, immunizations, or glasses
- Has periodontal disease and other untreated oral conditions
- Is consistently dirty, has poor hygiene, or has severe body odor
- Is insufficiently clothed for the weather

Child Behaviors

- Misses appointments for medical care
- Neighbors report child being left unsupervised
- Constantly tired or listless, passive or depressed behavior
- Frequently misses school without explanation
- States there is no one at home to provide care
- Begs or steals food or money; is hungry or malnourished

Parent/Guardian Behaviors

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Is chronically ill
- Has low intellectual functioning
- Has poor understanding of children's developmental levels and needs
- Has chaotic home life
- Behaves irrationally or in a bizarre manner
- Abuses alcohol or other drugs
- Has history of neglect as child
- Is poor

It is important to note that just because a family is living in an "at risk" environment (e.g., in poverty), does not mean that the parents are abusive. Likewise, some children may show indicators of abuse even if the family has no risk factors. Child Protective Services (CPS) workers, who are specifically trained to assess maltreatment, can help differentiate at-risk children and families from actual cases of abuse and neglect.

Reporting Child Maltreatment

Mandated Reporters

Mandated reporters are professionals who come into contact with children on a regular basis and who, in accordance with the federal law established under the Child Abuse Prevention and Treatment Act (n.d.; CAPTA; see Chapter 2), are required to contact the proper authorities about suspected child abuse and neglect (Delaronde et al., 2000; Kenny & McEachern, 2002). Although differences exist among states, mandatory reporters typically include the following professionals (*Mandatory Reporters of Child Abuse and Neglect*, 2008):

- Social workers
- Educators
- Health care professionals
- Mental health professionals
- Child care providers
- Law enforcement officers

States may specify persons considered as mandatory reporters. Among others included by various states are (*Mandatory Reporters of Child Abuse and Neglect*, 2008):

- Domestic violence workers
- Substance abuse counselors
- Firefighters
- Animal control officers
- Veterinarians
- Commercial film or photograph processors
- Members of the clergy
- Administrators and employees of public or private day camps, youth centers, youth recreation programs, or other youth organizations
- Coroners or medical examiners

When acting in their professional capacity, mandated reporters are encouraged to consult with their employers for existing protocols before contacting authorities. Most agencies, especially those that serve or work with children, will have procedures to follow before, during, and after the contact is made. Upon occasion, some employers have been known to resist having these reports made from their businesses for such reasons as fear of losing a client or insulting a patient. Regardless of the employer's response, the responsibility for protecting the child lies with the mandated reporter, who can be held legally responsible for failing to make the proper contact (Delaronde et al., 2000; Kenny & McEachern, 2002).

Privileged Communication

Because much of the information they receive is privileged, social workers are often conflicted when contacting CPS. **Privileged communication** is "the

statutory recognition of the right to maintain confidential communications between professionals and their clients" (*Mandatory Reporters of Child Abuse and Neglect,* 2008, p. 3). Privileged communication applies to social worker–client, attorney–client, clergy–penitent, and various other professional relationships as recognized within state and federal statutes. To be considered privileged, the communication must take place with the professionals acting in their particular roles that make them exempt from disclosure (CAPTA, n.d.). Outside of these professional relationships, information shared can be considered public.

Situations exist that can abrogate privileged communication, one of which is mandated reporting of suspected child abuse. According to CAPTA, exceptions to privilege include communication revealing contemplation or commission of a harmful act. Acts of expected or actual child abuse qualify under these criteria and therefore nullify confidentiality in many situations. These exemptions change depending on a professional's state of residence and specific circumstances; therefore all professionals would be wise to understand their state statutes applying to privileged communication and mandated reporting. A summarized listing of these laws is available through the Child Welfare Information Gateway (see *Disclosure of Confidential Child Abuse and Neglect Report,* 2008; *Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws,* 2008).

While obeying federal, state, and local law, social workers must also behave in accordance with the National Association of Social Workers (NASW) Code of Ethics (2008). Their commitment to clients (Standard 1.01) is superseded by the law of protection of humans from harm (also Standard 1.01). To avoid circumstances in which clients feel betrayed, social workers are to have their clients sign an informed consent at their initial meeting that clearly states the legal mandates regarding the disclosure of information (Standard 1.03). If clients reveal information that the social worker must report and additional harm will not occur with further discussion, the client can be consulted about making the call to authorities in conjunction with the social worker, thus exercising the client's right to self-determination (Standard 1.02). To learn more about the profession's laws and ethics, recommendations for further readings can be found at the end of this chapter.

The importance of privileged communication in the social work profession was officially acknowledged by the 1996 Supreme Court decision in *Jaffee* v. *Redmond* (Lens, 2000). In her role as a police officer, Mary Redmond shot Ricky Allen. Carrie Jaffee, the administrator of Allen's estate, sued Redmond in a civil case for using excessive force. During the discovery phase, it was revealed that Redmond had received psychotherapy from a social worker. Jaffee demanded disclosure of the social worker's records for use in the civil court case. Redmond refused, citing the psychotherapist–patient privilege. In weighing the issues of this case, the Supreme Court for the first time recognized the importance of a psychotherapeutic relationship as deserving of privileged communication. (Previously the privilege had been acknowledged in state law but not federal law.) Equally important to the social work profession, the Court recognized social work as demanding specialized training, on equal grounds with psychology and psychiatry; therefore any communications with a social worker under the form of psychotherapeutic treatment would also be protected as privileged (Lens, 2000).

Criteria for Reporting

Typically, reporting a case to CPS requires only two criteria: (a) suspicion of child maltreatment and (b) accurate reporting of the facts to the best of the reporter's ability (*Mandatory Reporters of Child Abuse and Neglect,* 2008). By meeting these two criteria, the report is considered to be made "in good faith." Reporters should call whenever they "suspect" or "have reasonable cause to believe" a child is or may be abused or neglected.

Substantiation of the maltreatment is the responsibility of CPS, law enforcement, and the courts. The CPS workers who take initial reports will determine whether there is reasonable and sufficient information to proceed further with the case. The responsibility of determining the reality of the maltreatment is with CPS from the time they receive the call until the case is closed (Kopels, Charlton, & Wells, 2003).

Where to Report

The most efficient and recommended contact for reporting a case of suspected child maltreatment is through the **State Central Register** (SCR), which is the entry point for CPS. A listing of state hotlines is available at the end of Chapter 2. The workers at the SCRs have expertise in taking reports and have resources available to them, such as past child abuse reports, which are not available at other reporting sites. After SCR workers speak with callers, they check their database to determine if previous reports have been made on the same family anywhere in the state. If further investigation is deemed appropriate, the SCR workers contact the local CPS office (Schene, 1998).

What to Report

The SCR workers taking reports have a series of questions about the child's endangerment. Reporters are not required to identify themselves and can remain anonymous. However, mandated reporters are expected to provide their names and affiliations; thus they establish evidence of having fulfilled their mandated responsibility (National Child Welfare Information Gateway, n.d.). Self-identification also ensures availability for follow-up contacts. Some states require mandated reporters to follow the oral report with a written report, which is usually submitted on a form made available by the state. Figure 3.1 is an example of one such form.

Reporters are asked to answer questions to the best of their ability. Answers to all the questions are not required for the investigation to be conducted. Typically, the SCR will ask the following:

- Child's name, date of birth, age, and address
- Child's present location
- Names and ages of siblings (if any)
- Parent or guardian's name and address
- Nature and extent of the injury or condition observed
- Reporter's name and location

3.1

Suspected child abuse report form.

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER | TITLE | MANDATED REPORTER CATEGORY

REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS | Street | City | Zip | DID MANDATED REPORTER WITNESS THE INCIDENT? • YES • NO

REPORTER'S TELEPHONE (DAYTIME) ( ) | SIGNATURE | TODAY'S DATE

B. REPORT NOTIFICATION

• LAW ENFORCEMENT • COUNTY PROBATION
• COUNTY WELFARE / CPS (Child Protective Services) | AGENCY

ADDRESS Street | City | Zip | DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - TITLE | TELEPHONE ( )

C. VICTIM One report per victim

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street | City | Zip | TELEPHONE ( )

PRESENT LOCATION OF VICTIM | SCHOOL | CLASS | GRADE

PHYSICALLY DISABLED? • YES • NO | DEVELOPMENTALLY DISABLED? • YES • NO | OTHER DISABILITY (SPECIFY) | PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? • YES • NO | IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: • DAY CARE • CHILD CARE CENTER • FOSTER FAMILY HOME • FAMILY FRIEND • GROUP HOME OR INSTITUTION • RELATIVE'S HOME | TYPE OF ABUSE *(CHECK ONE OR MORE)* • PHYSICAL • MENTAL • SEXUAL • NEGLECT • OTHER (SPECIFY)

RELATIONSHIP TO SUSPECT | PHOTOS TAKEN? • YES • NO | DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? • YES • NO • UNK

D. INVOLVED PARTIES

VICTIMS SIBLINGS

NAME | BIRTHDATE | SEX | ETHNICITY | NAME | BIRTHDATE | SEX | ETHNICITY

1. _____ 3. _____

2. _____ 4. _____

VICTIMS PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street | City | Zip | TELEPHONE ( )

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ● | *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

Legal and Ethical Issues in Reporting

False Reporting

Some individuals will purposely give false information about nonexistent cases of abuse or neglect. These malicious calls are more common in situations such as a divorce or custody battle, when one party is attempting to make the other look like a poor parent (Richardson, 2002). If the reporter can be identified, which is difficult because of the confidentiality provided to callers to SCR hotlines, and the report can be proven to be purposely malicious, the offended party can bring civil charges against the reporter. Unless proven otherwise, calls to SCR workers are considered to be made "in good faith"; thus callers are immune from prosecution.

Failure to Report

If, during an investigation of substantiated child maltreatment, law enforcement determines that a mandated reporter failed to make a referral of the suspected abuse to CPS, the individual can be liable for a civil suit or criminal charges (Richardson, 2002).

For social workers, failure to comply with this legal and ethical responsibility may result in review of their credentials by the National Association of Social Workers, as reported in the *National Association of Social Workers Procedures for Professional Review* (2005). The outcomes of this peer review process, although not intended to be punitive, could be termination of NASW-issued credentials, notification to state regulatory boards, and/or preclusion of practice. Because of these serious consequences, professionals are encouraged to take steps to ensure that they can recognize and report suspected child maltreatment and that they carry through with proper procedures.

Confidentiality

Reporters who provide their names to the SCR are guaranteed confidentiality in accordance with CAPTA. All information in CPS records is confidential, and reporters' names are protected under strict penalty of law. Accepting reports anonymously and guaranteeing confidentiality are means of encouraging people who suspect abuse to call the authorities without fear of retribution.

Reporters' names are available only to specific persons under certain circumstances. The CPS workers involved in the case, for example, will know the reporter. If the case goes to court and the reporter's name is requested by the attorney, the judge will request disclosure only if the name is pertinent to the public interest and to the case.

Other professionals who are most likely to view reporters' names are physicians, researchers, police, judges, and other court personnel. The most common situations in which reporters' names are accessed occur in cases of child fatalities or near fatalities due to acts of abuse and neglect. All of these individuals, having access, are held legally accountable to keep reporters' names confidential; otherwise civil and criminal charges may be filed against them (*Disclosure of Confidential Child Abuse and Neglect Report,* 2008).

Release of general information within CPS records is allowed under certain circumstances, such as employment screenings. If an individual applies for a position that involves frequent access to children, the potential employer is allowed to discover whether the applicant has substantiated or indicated reports of child maltreatment filed against him or her (Kopels et al., 2003; Schene, 1998; Waldfogel, 2000).

Underreporting

Despite the precautions to protect reporters, cases of child abuse and neglect are seriously underreported by professionals, including educators, social workers, mental health workers, and medical personnel. Studies have found that less than 30% of teachers reported suspected cases of abuse or neglect (Kenny, 2001). An estimated 51% of social workers, 58% of psychiatrists, and 44% of psychologists failed to report suspected cases of abuse (Weinstein et al., 2000). Of health professionals, only 47% reported suspicious cases (Russell, Lazenbatt, Freeman, & Marcenes, 2004; Vulliamy & Sullivan, 2000).

Dentists tend to underreport cases of suspected abuse, even though 50% to 75% of child abuse results in trauma to the mouth, face, and head and even though head injury from abuse causes 40% to 70% of disabilities and deaths in children (Bsoul, Flint, Dove, Senn, & Alder, 2003).

Numerous reasons are given by professionals for not reporting suspected maltreatment. Among them is the fallacy that the suspected abuse is not severe enough and that they are waiting to see obvious signs of physical abuse before they call (Kenny & McEachern, 2002). Some mandated reporters do not believe they have sufficient expertise to make a report. If they do make a report, they are apprehensive that their accusations will not stand up in court, or they have concerns about being required to testify (Kenny, 2001; Portwood et al., 2000).

Social workers, especially those in therapeutic positions, may be hesitant to contact CPS. Although required to inform their clients of their legal mandate to report child abuse, workers often fail to have the informed consent signed (Weinstein et al., 2000). They are apprehensive that their working relationship with clients will be destroyed and believe that CPS will not only fail to help the family but may in fact harm the family (Delaronde et al., 2000). While some of these reasons have more merit than others, the fact remains that children's safety is largely dependent on professionals abiding by their legal and even moral responsibility to report suspected abuse.

The number of reported cases of suspected child abuse and neglect might increase if specialized training were provided for professionals in various disciplines (Bsoul et al., 2003; Kenny, 2001; Portwood et al., 2000; Russell et al., 2004). Included in this could be information about child development; training in how to recognize abuse or neglect; a definition of the roles and responsibilities of CPS; clear definitions and protocols for reporting; and ways of communicating with parents or guardians when making a report. Interagency referrals must be clearly delineated. Legislation and policies must protect all professionals whatever their field from fear of legal repercussions. These measures can help reduce apprehension about reporting and increase the likelihood of accurate and efficient reporting.

Investigation and Child Protective Services

Referrals reach CPS from many sources (see chapter 2). One source is from law enforcement officers, who may call from the scene of an investigation where children are involved and are considered endangered (Portwood et al., 2000). Officers' responsibilities entail determination of criminal charges and, when possible and appropriate, officers call upon CPS workers to assess the safety of the children. Law enforcement and CPS work closely with one another in various capacities for the protection of children (see chapter 4).

Law enforcement may call the local CPS office; however, most calls are made to the SCR, at which point the investigative process begins. Established under CAPTA, CPS is a governmental organization that exists in all 50 states, is staffed by social service workers, and has the primary responsibility for investigating reports on suspected maltreatment of children. Its core functions are to (a) respond to reports of children at risk of maltreatment; (b) assess the safety and risk of children in the care of their legal guardians; (c) assemble resources to strengthen families' abilities to care for their children; (d) provide for alternative care for unsafe children; and (e) evaluate the progress of families' abilities to care for their children (Schene, 1998). These workers make critical decisions about children's lives. Specialized education, ongoing training, and hands-on experience are necessary to competently meet the demands of these positions.

Reprofessionalization is the terminology used for the purposeful provision of specialized education and training for CPS workers (Alperin, 1996). As recognized by national organizations such as the Child Welfare League of America (CWLA), the most appropriate education for caseworkers is a Bachelor of Social Work (BSW) and/or a Master of Social Work (MSW) degree. The Council of Social Work Education (CSWE) accredits social work programs in higher education and assures continued quality education through its reaccreditation processes.

Among the vast training CPS workers receive is the process for investigating cases of reported child abuse or neglect (Schene, 1998). This process requires CPS workers to make numerous decisions, collaborate with other professionals throughout the community, interview concerned parties, understand the legal system, and conduct a myriad of other duties, which are only briefly presented in the following explanation (Schene, 1998; see Figure 3.2).

Step 1: Identifying and Reporting

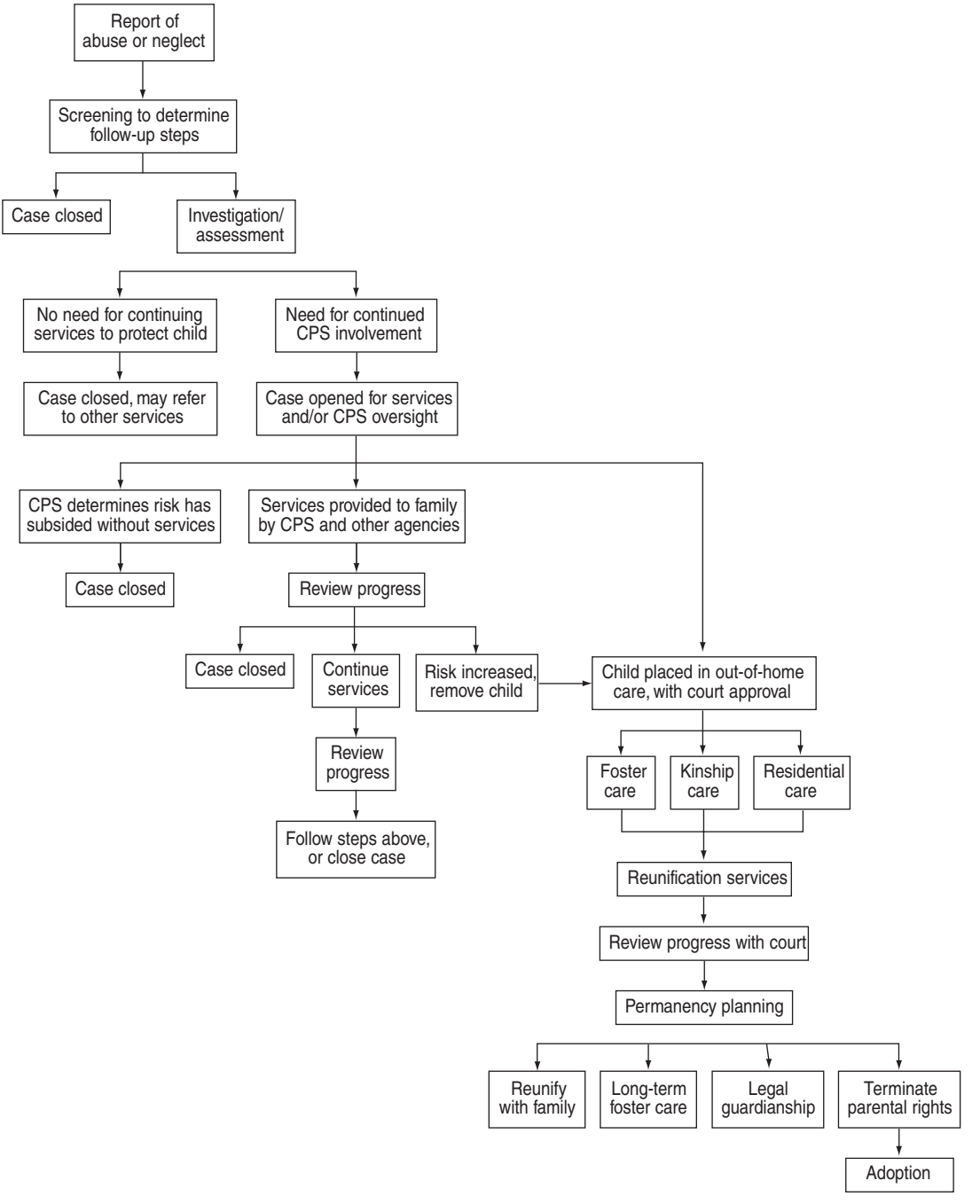
All other steps depend upon members of the community reporting suspected child maltreatment to the SCR, which operates 24 hours a day, 7 days a week. The numbers for each state are listed in Appendix A.

Step 2: Screening

The SCR worker gathers information to determine if the report meets statutory and agency guidelines. The worker provides support to the reporter; handles any emergencies including determination of the child's safety; verifies from past records whether a prior report has been made on the child; and documents

3.2

Overview of steps followed by cases through the child protective services and child welfare systems.



information about the child, family, and type of maltreatment. Whether the report meets statutory and agency criteria will depend on the state in which the report is made.

A call may be "screened out" if it does not meet statutory and agency guidelines. A call that is screened out at intake may be closed either without further action or after referring the case to another agency that can better serve the children and their families based on the identified problem (e.g., truancy, learning disability, lack of support during a crisis). All screened out calls are identified as situations in which the child is not endangered (Schene, 1998).

If a report meets statutory and agency guidelines, it is considered "**screened in**" to CPS. The next decision is the urgency of the response needed by a CPS worker in the field (i.e., making face-to-face contacts) to protect the child. Response times are usually "immediate," "within 24 hours," or "not within 24 hours." This decision, like others, is based on written guidelines, policies, and workers' expert judgment about issues such as severity of the maltreatment and vulnerability of the involved child (Kopels et al., 2003).

Step 3: Initial Investigation and Assessment

The initial contact with the family consists of two separate but related parts taking place simultaneously—the investigation and the assessment. The purpose of the "**investigation**" is to determine whether the abuse occurred. The purpose of the "assessment" is to evaluate the child's safety and/or risk. Law enforcement may accompany CPS in situations where the worker may be endangered, charges are severe, or alleged abusers are caregivers other than the parents, such as day care providers, teachers, or foster parents (DePanfilis & Salus, 2003; Goldman, Salus, Wolcott, & Kennedy, 2003).

If the investigation reveals no evidence of maltreatment, the worker will close the case and the allegation will be considered "unsubstantiated" or "indicated." "Unsubstantiated" implies that no abuse or neglect was evident. "Indicated" implies that the family needs assistance but not for problems qualifying under child maltreatment policies. For "indicated" cases, the worker refers the family for the appropriate services to meet their identified needs (DePanfilis & Salus, 2003)

If the investigation reveals evidence of child maltreatment, the case is considered "substantiated," and the caseworker continues with the assessment. The **initial assessment** considers two aspects—the child's *safety,* which refers to the possibility of immediate endangerment, and the child's *risk*, which refers to the possibility of future endangerment. This entire initial assessment may last 30, 60, or 90 days depending upon individual state policies.

During this investigation period, the caseworker involves as many individuals as needed to assure the children's safety from both immediate and future endangerment (Kopels et al., 2003; Schene, 1998). The reporter may be contacted for any further information that would assist in the assessment process. The immediate and extended family members may be involved if possible and if they allow it. Information is also gathered from neighbors, relatives, schools, health care professionals, and other parties.

The juvenile and family courts may hear the allegations if their involvement is considered advisable for the protection of the children and/or if the

children have already been placed in custody. If the court decides that the children require involvement of CPS and are placed in temporary care (other than the legal guardians), other players become involved, such as a court-appointed special advocate and guardian ad litum (see Chapter 4). If charges are pending, law enforcement becomes involved; and if the children are placed out of their homes, the prosecuting attorney's office becomes closely involved in the case. Most importantly, the children are kept in contact by CPS and other involved professionals (DePanfilis & Salus, 2003; Schene, 1998).

Although, in general, family preservation is the preferred outcome, children's safety takes precedence over preserving or reunifying the family, in accordance with the Adoption and Safe Families Act (ASFA; Pabustan-Claar, 2007). If the child is endangered within the home and may not be safe until the initial assessment has been completed, either the child or the suspected abuser may be removed from the home. If the children must be removed from home, the CPS worker makes decisions as to their placement based on **intrusiveness criteria** (i.e., disturbing to the child's normal, yet healthy, life), and the least intrusive measure is taken. Preferably, if the abusive caregiver lives within the home, he or she may be removed so that the child can stay. The next least intrusive measure is placing the child with a relative, which is known as **kinship placement**. The most intrusive measure is to place children in foster care or other out-of-home placement (DePanfilis & Salus, 2003).

Regardless of the children's placement, the second part of the assessment takes place. "Risk" refers to the potential for the child to be harmed in the future. When CPS was established in the 1970s, workers would use their professional judgment to determine risk (Hughes & Rycus, 2007); however, "even the most experienced and capable social workers often found it difficult to accurately estimate the level of risk in each case situation" (Hughes & Rycus, 2007, p. 86).

During the early 1980s, various states adopted the concept of using **risk assessment** instruments (psychometrically sound tools) to help workers in their decision making. In 1990, Wald and Wooverton published an article in *Child Welfare* entitled "Risk Assessment: The Emperor's New Clothes?" which discussed the methodological problems with existing instruments (Hughes & Rycus, 2007, p. 87). To be considered useful and effective, such instruments must have established **validity** (the ability to accurately measure what the instrument is designed to measure) and **reliability** (consistency in measurement; Hughes & Rycus, 2007). This publication, and the discussion that followed, generated intense efforts to design instruments that would prove effective in assessing child endangerment.

Over the years risk assessments have been refined and empirical evidence has accumulated as to their ability to predict harm to children by their caregivers (Ethier, Couture, & Lacharite, 2004; Fuller, Wells, & Cotton, 2001). Risk assessment systems have provided more uniformity in decision making across different workers, agencies, and systems. Ultimately, they are intended to help make better decisions for families (Baird, Wagner, Healy, & Johnson,1999).

Each state and agency determines the instruments to be completed by its CPS workers. Two basic types of instruments are *consensus-based* and *actuarial*. Consensus-based instruments rely on clinical experience, intuition, and interviewing skills for assessing risk (Baird et al., 1999). **Actuarial instruments** are based on empirical evidence, such as the data gathered through research

studies (i.e., numbers and measurements). The actuarial systems seem to be more widely accepted by CPS organizations, and the results of their use indicate more uniformity among workers' decisions (Baird et al., 1999).

Two consensus-based systems are (a) the Washington Risk Assessment Matrix (WRAM), which was developed by the Washington State Department of Social and Health Services, Division of Children and Family Services, in 1987, and (b) the California Family Assessment Factor Analysis (CFAFA), "a derivative of the Illinois Child Abuse and Neglect Tracking System [CANTS] system [California State University 1987]" (Baird et al., 1999, para. 21). The WRAM includes six risk categories, assumes that child maltreatment will occur, and predicts severity of maltreatment. The CFAFA predicts risk using factors about the incident, child, caregiver, family, and family/agency interaction.

One of the most widely used actuarial-based approaches is the Michigan Structured Decision Making System's Family Risk Assessment of Abuse and Neglect (FRAAN; Baird et al., 1999, para. 21). The FRAAN is used for determining the level of imminent risk and uses factors of neglect, abuse, and caregiver strengths.

Although risk assessment instruments are widely used, they do not always improve on workers' decision making and can provide inaccurate information (DePanfilis & Zuravin, 2001). The short time frames within which workers must respond can result in inaccurate completion of plans that use "simplistic and . . . 'boilerplate' language" (Hughes & Rycus, 2007, p. 91). The assessments may be designed for one purpose, but they are used for a myriad of purposes not intended for the instrument (DePanfilis & Zuravin, 2001). The terminology within the literature varies widely, to further confuse the purpose and use of various instruments.

Use of risk assessment instruments cannot replace competent, trained caseworkers, and agencies cannot use instruments instead of providing the resources needed to retain experienced workers. Risk assessments and other measuring tools must be placed in the hands of experienced caseworkers having the ability to make educated, professional judgments while incorporating these tools (Ethier et al., 2004; Fuller et al., 2001).

Step 4: Family Assessment

The assessment process, while determining the child's safety and risk, incorporates information about the family. The CPS worker collaborates with the family, while remaining culturally competent and building on the family's strengths, to identify problems, plan for solutions, and prepare for service delivery. During this entire time, the worker must help the children cope with any consequences of the maltreatment, possible removal from their home, and other changes taking place in their lives (DePanfilis & Salus, 2003).

Step 5: Planning

Based upon the information gathered in the initial and family assessments, the caseworker writes a case plan in conjunction with the family. The strategies in the **case plan** include goals and objectives that provide for the children's safety

and placement as well as for the entire family's well-being. Goals are broad statements about areas of the family members' lives that are to change for the children's well-being (such as the parents' abstinence from drug use and obtaining employment). Objectives are more specific steps the family members must take to achieve their goals. These objectives should be "SMART"—specific, measurable, achievable, realistic, and time-limited. A possible objective for abstinence from drug use, for example, could be attendance at Alcoholics Anonymous meetings four times a week for 3 months (DePanfilis & Salus, 2003).

Two plans are written concurrently, and both are signed by the family members. One plan anticipates that the children either remain in or (if removed) return to their home; whereas the other plan takes effect if the children must be removed (or remain away) from their home for their own safety. This signing of both plans is required to keep CPS in compliance with the Adoption and Safe Families Act (ASFA) of 1997, which was passed to keep children from lingering in out-of-home placements (Pabustan-Claar, 2007). According to the ASFA, either reunification between the children and their parents takes places within a specified, reasonable length of time or parental rights to the children are terminated, enabling the children to be adopted by a responsible adult.

Step 6: Service Provision

Proceeding with the plan of preserving the family, the CPS worker helps the family to implement its plan and meet its goals. During the provision of services, the caseworker assumes a case management role, thus, providing continuity of care that is accessible, efficient, and accountable. Services may be sought to fulfill needs such as education, employment, physical and mental health evaluations and provisions, housing, substance abuse, welfare benefits, and child care services. The plan may be revised as objectives are met or as other needs arise. The extensiveness and timing of the services that are provided depend upon the parents' readiness to make those changes that can assure their children's continued protection from further maltreatment.

Step 7: Evaluation of Family Progress

The CPS worker continues the assessment process, including ensuring the children's safety, reducing risks of maltreatment, evaluating the achievement of family outcomes, and reviewing the family's progress. The assessment, planning, service provision, and evaluation steps continue until closure of the case.

Step 8: Case Closure

Cases can be closed with various outcomes for the children. If the children remain in their home and the home is considered safe, the case is closed to CPS. Referrals for services can continue to be made to meet the family's needs.

If the children were removed from the home and the home is now considered safe, *reunification* may take place. Reunification is the reuniting of the children with their parents. Continued services and referrals are made until CPS closes the case.

If the children were removed from the home and reunification could not be made, alternative plans are made for the children. At this point parental rights are terminated. The children's care is awarded to a permanent legal guardian or to an adoptive parent. If neither of these placements is possible, the children remain in foster care until they reach age 21, at which time they are emancipated.

CPS uses this process for addressing the millions of cases referred to them annually. Their involvement with families is intense and time-consuming. The ultimate goal is protection of children from endangerment in their own homes; however, CPS works diligently to provide the services that families need in order to remain united.

Alternative Responses to CPS

Problems with the CPS system are ongoing, and alternative paradigms have been suggested to help rectify them (English, Wingard, Marshall, Orme, & Orme, 2000). Some critics point out that CPS uses two opposing missions (Schene, 1998). For protecting children, CPS uses a *deficit* model (Schene, 1998, p. 31), which places responsibility for maltreatment on the parents. For working with families, CPS adopts a *family-strengths model*, which places responsibility on environmental factors such as poverty and institutional violence (Schene, 1998). These two opposing views sometime result in confusion and mixed messages to families and the public.

The sheer number of cases is also is cause for concern. CPS has an "overinclusion" of cases, which means they are called upon to investigate such a large number of cases that the more serious ones do not always get the attention they need (English et al., 2000; Waldfogel, 2000). Sometimes the number of families that are referred exceed the system's capacity to respond appropriately. When services are provided, they tend to lack cultural sensitivity and instead use a "one size fits all" approach (Waldfogel, 2000, para. 7). Lack of appropriate responses result in "underinclusion," meaning that people are hesitant to report cases that should be reported because they do not believe the situation would be properly handled by the system (Waldfogel, 2000).

In efforts to address these problems, alternative paradigms that use dual or multitrack options are being established. They are commonly referred to as **community-based alternative response systems** (CBARS), such as the one currently utilized in the state of Washington (English et al., 2000). Reports that do not involve imminent danger are referred to alternative agencies, and families are offered assistance without involvement of CPS. These options enable families to work with caseworkers in establishing their case plan, implementing the plan to receive necessary services, resolving their situation, and returning to a healthy lifestyle. These services then free CPS to attend to the more serious cases.

Recurrent Reports

The involvement of CPS and alternative response agencies is intended to solve the problems of the referred families. Of these families, only 5% have just one reported form of maltreatment (Ethier et al., 2004). The rest are multiproblem

families who are repeatedly engaged by CPS. As many as 70% of them are re-reported as many as four times in a 5-year period (Wolock, Sherman, Feldman, & Metzger, 2001). This re-reporting is associated with risk factors within the family and certain individual, family, and social characteristics. Some of these risk factors are (a) parental substance abuse; (b) low intellectual functioning due to limited education and/or emotional challenges of a family member; (c) mother's history, such as foster care placement, sexual abuse as child, or runaway as a child; (d) poor family functioning, such as violence in the past or present family, social isolation, or stress; and (e) poverty because of low income, a large number of children, and/or unemployment (Connell, Bergeron, Katz, Saunders, & Tebes, 2007; Ethier et al., 2004; Fuller et al., 2001; Wolock et al., 2001). These recurrent reports place additional pressure on a system that is already overworked. More effective methods of working with such families, as well as the implementation of alternative responses, will perhaps ultimately better serve them and all children experiencing family violence.

Summary

The information in this chapter focuses on identifying, reporting, and investigating families suspected of child abuse and neglect (CAN). Indicators of these families can often be identified by the appearance and behavior of children and their parents. Common indicators include families living in low socioeconomic conditions; suffering increased stress due to unemployment, disabilities, or loss of their support system; having negative attitudes toward children; and abusing substances. In accordance with the Child Abuse Prevention and Treatment Act (CAPTA), professionals having frequent contact with children and their families are mandated to report suspected child maltreatment, and responsible adults are expected to make these reports.

The only criteria for reporting child maltreatment are suspicion of abuse and the call being made "in good faith." Following these guidelines, reporters are immune from legal ramifications. Prosecution, or other negative consequences, is more probable for mandated reporters not fulfilling their responsibilities. Privileged information to social workers is usually nullified by their legal and ethical responsibility to report child maltreatment.

Over half the cases reported to CPS are made by professionals; however, another 30% to 59% go without being reported. The reasons for nonreporting appear to include lack of professional guidelines and protocol; skepticism in the investigation and criminal justice systems; and fear of parental disapproval. Potentially, this underreporting could be rectified with proper training and with the implementation of alternative responses to CPS investigations.

When cases are reported to CPS, the workers follow a process for investigating and intervening with families. This process begins with the identification and reporting of the maltreatment. During the intake step, CPS workers gather data to either "screen out" the report, which may be done with or without service referrals, or "screen in" the report, which means further steps are required to assess the validity of the report.

The initial investigation and assessment involves two separate but related, parts. The investigation is to determine whether abuse occurred, and the assessment is to evaluate the safety and risk to the child. CPS workers use psy-

chometrically designed risk assessments to assist in their decision making. In cases where children have been maltreated, the CPS worker and family proceed to the family assessment, planning, and service provision steps, during which other resources are used to help the family stay unified, become reunified, or sever parental ties. During the evaluation step, recommendations are made to the courts, and case closure follows the final placement of children in a permanent home where they can be safe from harm.

Shaken, Slammed, Beaten, Squeezed: Dominic James

The August 2002 death of 2-year-old Dominic at the hand of his foster father set off a firestorm, prompting an overhaul of Missouri's child welfare laws and exposing deficiencies in the training of mandated reporters.

Dominic's foster father, John W. Dilley, 40, of Willard, was convicted in 2003 of second-degree assault and child abuse resulting in the boy's death, which has been described as a classic case of shaken baby syndrome. Dilley is serving a 15-year prison sentence.

Taken from his parents after a domestic dispute in June 2002, Dominic was placed in foster care with Dilley and his wife by the Department of Social Services Children's Division, then known as the Division of Family Services.

Two months later, Dominic was flown to Cox South hospital with seizure-like symptoms.

Despite concerns raised by the boy's parents and a call made to the state child abuse hotline, he was released four days later and returned to the foster home. Four days after that, he was back in the hospital with similar symptoms.

On the second hospital visit, Dominic slipped into a coma and died.

Charges against a Cox South hospital nurse who allegedly failed to report signs of abuse during the first hospital visit were eventually dismissed, although Dominic's father and mother separately sued state child welfare workers for failing to protect the boy. Both lawsuits were unsuccessful. (Bridges, 2008)

—From an article by Amos Bridges published in the *Springfield News-Leader* (MO), January 20, 2008.

Discussion Questions

1. In retrospect, the decision to allow Dominic to remain in the foster care home was wrong; however, the parents failed to win their suit against

(continued)

the child welfare workers. How appropriate were the actions taken by DFS following the meeting with the team of other professionals?
2. The three individuals sued were the nurse, for failing to report signs of abuse, and the two DFS workers. How justified were the parents in suing these three professionals? What other way could this situation have been handled other than lawsuits?
3. What are the differences in removing children from a parent's home and removing them from a foster care home?
4. What can be done to make the system safer for children?

Key Terms

Actuarial instruments
Case plan
Child maltreatment
Community-based alternative response systems (CBARS)
Indicators
Initial assessment
Intrusiveness criteria
Investigation
Kinship placement
Mandated reporters
Privileged communication
Reliability
Risk assessment
Risk factors
Screened in
State Central Register
Validity

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The Criminal Justice System and Child Maltreatment

4

As Mother Goes on Trial for Child's Death, Attention Turns to Her Minister

It's been more than two years since 4-year-old Sean Paddock suffocated to death in the farmhouse where social workers had sent him to live with a new set of parents. A day of reckoning begins Monday for his adoptive mother, Lynn Paddock. A jury will be asked this week to convict Paddock, 47, of first-degree murder in Sean's death and of felony child abuse for the beatings of two other children. Sean stopped breathing after he was bound so tightly in blankets his lungs couldn't fill with air; investigators have said that Paddock wrapped him in blankets to keep him from wandering the hallways of their remote farmhouse through the night. . . . Locally, investigators cringed and social workers shook their heads as each

(continued)

detail of the death showed another frailty of a system designed to protect vulnerable children.

Sean's death also stoked a fire already blazing around . . . a controversial evangelical minister from Tennessee who coaches parents on how to raise docile, God-fearing children. Lynn Paddock had turned to his guidance to help rear her growing flock of adopted children.

The siblings that survived a life in the Paddocks' home will be grilled by lawyers about Lynn Paddock's discipline tactics. Lawyers are expected to argue to a judge today whether to allow the jury to see video testimony of Sean's two older siblings, also adopted by the Paddocks. Several other Paddock children will be expected to testify as well. (Locke, 2008)

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In the case at the start of this chapter, Child Protective Services (CPS), in collaboration with other child advocacy workers, arranged for two of Lynn Paddock's children to be videotaped as they answered questions about their knowledge of life at the Paddock residence. CPS workers appear in juvenile court on a regular basis as part of their responsibilities in protecting children. When subpoenaed by a prosecuting or defense attorney, they, as well as other social workers, also may appear in criminal court to present either factual or expert testimony.

Because of their responsibilities within the criminal justice system, social workers need a working knowledge of government branches; child-protection laws; court jurisdictions; types of evidence; specialized court services; investigative interviewing of abused children; strategies for testifying; roles of other professionals within the system; and other matters that can assist them in working with the courts. This chapter provides an introduction to all of these topics. At the end of the chapter, recommended readings provide further information about the court system and the social worker's role within it.

Government Branches and Laws

The U.S. Constitution divides the federal government into three branches: (a) the executive branch (the office of the president); (b) the legislative branch (Congress); and (c) the judicial branch (the court system). Likewise, state constitutions divide their governments into three branches: the governor's office (executive), the state congress (legislative), and the state courts (judicial). Both the federal and state constitutions include a bills of rights.

Laws are rules that determine how members of society are to behave (Brayne & Carr, 2008). In the United States, laws are established by federal and state governments through three methods: regulations, statutes, and court decisions (Myers, 1998).

Regulations are established by the agencies of the executive branches and are set forth in the Code Book of Federal Regulations or state administrative

code books, respectively. Codes "define child abuse and neglect and establish punishments" (Myers, 1998, p. 47).

Statutes are referred to as "public laws," which are passed by congress; they include some of the laws that are most applicable to social workers. An example of a federal statute is the Child Abuse Prevention and Treatment Act (CAPTA), which has been discussed in previous chapters. State statutes "create CPS agencies, juvenile courts, and other social agencies" (Myers, 1998, p. 47) which then develop their own processes for handling cases of child abuse and neglect.

Court decisions, which are referred to as **common laws,** are legal decisions made by judges in cases where no legal precedent exists. Attorneys will often point to relevant or similar court decisions to argue on behalf of their clients. An example of a common law at the federal level is *Maryland* v. *Craig* (1990), "[in which] the U.S. Supreme Court ruled that certain traumatized children may testify without having to face the person accused of sexually abusing them" (Myers, 1998, p. 48).

Local governments also pass laws that apply to the welfare of children. In addition to these laws, social workers who work in agency settings must also follow policies and procedures established by their employer. Thus before appearing in court, social workers are advised to consult with their agency as to established standards as well as to be familiar with whatever local and state laws may apply. Social workers play a unique role within the court system for the protection of children.

The Criminal Justice System

The judicial system comprises two primary types of courts: civil and criminal. Child maltreatment cases are frequently handled by family courts, which are a subset of the civil court system.

Civil courts hear cases that do not involve the breaking of criminal laws, but rather issues such as contract disputes, property damage, minor injuries, and compensation from accidents (Brayne & Carr, 2008). These are the types of cases that appear on television shows such as *Judge Judy*. Specific types of civil courts are **family courts** and **juvenile courts.** Family courts commonly hear divorce, child support, and child custody cases. Juvenile courts have jurisdiction (the authority to act) on cases involving children under the age of 18 and handle both child maltreatment and delinquency cases.

Criminal courts have the authority to impose penalties on persons charged with breaking the law. If an adult charged with child abuse is already involved in criminal court, the judge can maintain jurisdiction over the accompanying or subsequent child abuse case; however, typically abuse cases are turned over to the juvenile courts. The rest of this chapter concentrates on the juvenile and criminal court jurisdictions, particularly their procedures in child maltreatment cases.

Juvenile Courts

Juvenile courts are charged with protecting children who are considered endangered within their own homes. These courts are separated from other courts

(family, criminal) by their jurisdiction and often even by physical location. The judges who preside over juvenile courts specialize in laws pertaining to children and are knowledgeable about the social service provisions for them.

Juvenile courts tend to be less formal than criminal courts, so as to help children feel more comfortable. Only the judge makes the final ruling; no jury is present. The hearings are private, thus, only concerned parties may be present. Individuals present their testimonies to the judge (Myers, 1998).

The professionals within the system are dedicated to representing children's best interest. This is not to say that they do not disagree; however, when controversy and opposing legal positions are presented, the judge makes the final decision on behalf of the child's well-being. No criminal charges are heard in this court; no civil disputes are settled. Juvenile court judges are responsible for the future of the children appearing before them and as such assume the role of ***parens patriae***, which means acting in the position of the parent (Myers, 1998).

If CPS, during the initial investigation (see Chapter 3), determines that a child is in imminent danger, the child will be temporarily removed from the parents' home and be placed in emergency kinship (relative) care or foster care. Within 24 to 48 hours from the time of removal, a **detention hearing** must be held before the juvenile court judge to determine if sufficient evidence exists for CPS to continue maintaining jurisdiction over the case until further hearings can be held (Myers, 1998). The prosecuting attorney's office will file a **petition** (document) with the court containing the **allegations** (reasons) why the child should be considered dependent on the court for protection.

At the detention hearing, the prosecuting attorney represents the state; the parents have the right to legal counsel (a defense attorney). If they cannot afford counsel, one will be appointed by the judge. Often the state defense attorney's office assumes this role. The court hears testimony from concerned parties such as the CPS worker, the child, parents, and any other individuals having knowledge of the allegations in the petition. If the judge believes the child is in danger and must remain under the jurisdiction of the court pending further investigation, the child may continue to be detained out of the parents' custody. (If the child has not been removed from the home, the detention hearing is unnecessary; the **adjudication hearing** marks the first time the child and parents appear before the court.)

Within 30 days of the detention hearing, the adjudication hearing is held to determine if the children are dependent on the court for further protection. The judge hears testimony from all parties involved in the case, including CPS, the child, parents, attorneys on behalf of the state and parents, and representatives from various specialized court services. If the judge believes the allegations in the petition, the child is adjudicated as "dependent on the court" and a dispositional hearing is scheduled.

A **dispositional hearing** may be held simultaneously with the adjudication hearing or may be scheduled for a future date (within 30 days). At the dispositional hearing, the court determines the child's placement until he or she is no longer dependent on the court for protection. Throughout this entire process, CPS caseworkers are assigned to assess and provide services to the children and their parents and to coordinate planning with other professionals.

The ultimate goal in abuse cases is family reunification if at all possible. If the children are removed from the parents' custody, the CPS worker, in col-

laboration with the parents, write a **permanency plan.** It outlines the goals and objectives to be achieved, within a specified time line, to enable the children's return to the parents' custody.

Criminal Courts

The criminal courts hear cases in which adults have been charged with misdemeanors or felony offenses. In cases of child maltreatment, juvenile court judges hear the testimony pertaining to children's safety and placement; whereas criminal court judges determine the guilt or innocence of the parents in committing the abuse. If the parents are found guilty, the court is responsible for sentencing them.

Criminal courts are more formal than juvenile courts. In a criminal court case, the **complainant** is the state in which the crime took place, and the suspect is the **defendant**. The prosecuting attorney's office represents the state, and—unless the defendant wishes to represent himself or herself—a private or public defender represents the accused. Defendants are permitted a jury trial. Witnesses are subpoenaed by the attorneys, at which time they testify and are cross-examined.

Only about one-quarter to a half of the cases that go to juvenile court also go to criminal court (Stroud, Martens, & Barker, 2000). Most of these cases involve child physical and sexual abuse as well as serious neglect (Cross, Finkelhor, & Ormrod, 2005). The reasons why a prosecuting attorney's office might decline to take a case to criminal court vary, but one basic tenet is whether sufficient proof is available to make a strong case against the suspect. Reasons for not filing charges might include changing of the child's story, age of the child (younger children are often less able to testify persuasively than older children), gender (girls are willing to tell their stories more readily than boys), relationship between suspect and child (children are reluctant to testify against their own parents), severity of injury (the ability to substantiate the timing between injury and charges), perpetrator's prior criminal history, and cultural factors (Stroud et al., 2000). Determining whether to take a case to criminal court is largely dependent upon the available evidence, which "is anything that helps prove a point. . . . [and can be] testimony from expert witnesses, written documents, photographs, and objects" (Myers, 1998, pp. 228–229).

The rules for admitting evidence and for winning a case are more stringent in criminal court than in juvenile court. In juvenile court, only a **preponderance of evidence** is required, which means that the evidence presented favors the state (child) rather than the parents and is enough to convince the judge that the child is in danger. In criminal court, evidence must be *beyond a reasonable doubt,* which means that the jury is absolutely convinced of the charges against the defendant (Myers, 1998).

Various types of evidence may be presented in court. **Real evidence** involves tangible objects, such as photographs of injuries or weapons. **Documentary evidence** consists of authenticated documents, such as case files or doctors' reports. **Testimonials** are oral statements by witnesses. **Hearsay evidence** is testimony made out of the courtroom to another individual; it can apply to what someone heard or saw other people say or do (Myers, 1998).

Hearsay evidence in child maltreatment cases typically consists of something the child described to another individual before the court proceeding took place. The use of hearsay evidence is often inadmissible in criminal cases, especially if the defense has no opportunity to cross-examine the child who actually made the statement. Hearsay evidence and its admissibility is complex, even to attorneys (Myers, 1998). To be admissible, hearsay evidence must use the child's exact words, describe something that happened (such as the abuse), be spoken prior to the court proceedings, and be intended to prove the abuse happened.

States have exceptions to hearsay that can be used to allow evidence in court. One of these is the child's **excited utterances,** which are a child's statements about a startling event, such as recent abuse. Another is the **state-of-mind exception,** which comprises statements indicating pain or fear. Another exception applies to statements made to medical professionals in the process of the medical diagnosis or treatment (Myers, 1998, p. 162). Whether testimony adheres to the exceptions of hearsay or is admissible as hearsay evidence is inevitably debated between the attorneys and decided by the court.

Other Professional Roles in Child Maltreatment

Throughout the court procedures described above, the victims of child abuse and neglect are protected and represented by professionals from various agencies and professions, including CPS, law enforcement, education, child care, health care, mental health, the judiciary, substitute care, religious communities, support services, and the community at large. These professionals work collaboratively to provide comprehensive assessments and services. Some of their roles are described in the following sections.

Law Enforcement

Law enforcement and CPS coordinate their investigations when the complaint involves a criminal charge. In these cases, police officers visit the home at the same time CPS does (as described in Chapter 3). Law enforcement has both the power and the responsibility to protect the health, safety, and welfare of children; thus, police officers have the authority to remove children from the custody of their parents if abuse or neglect is suspected. When removal is necessary, CPS places the children in alternative care (Cross et al., 2005).

In this coordinated effort, problems arise for both agencies; these stem from their conflicting philosophies, styles, and responsibilities (Cross et al., 2005). Law enforcement officials want to keep the scene of the crime uncompromised and arrest the perpetrator. They need to directly question involved parties and gather information. Once the perpetrator is arrested, law enforcement officers have fulfilled their principal responsibilities.

CPS acts on behalf of the child's safety, and, at the same time, must build a rapport with the family—even if the child is removed. CPS's involvement with the family continues until the child is permanently placed. CPS can interfere with law enforcement by interfering with evidence and the criminal investigation (Cross et al., 2005). Law enforcement can interfere with CPS by taking

punitive interventions and interfering with CPS's effort to protect the child and repair the family (Cross et al., 2005).

Multidisciplinary Teams

One attempt to increase collaboration between these two agencies was the formulation of **multidisciplinary teams** (MDTs). These teams have existed for over half a century as a way to improve the efficiency and effectiveness of services to abused and neglected children. Some of the more common models of MDTs are **child advocacy centers** (CACs), which focus on sexually abused children ages 12 years and under, and **child protection teams** (CPTs), which focus on severe cases of physical, sexual, and medical neglect of children under 5 years of age (Wolfteich & Loggins, 2007). In addition to improving efficiency, the purpose of these teams is to decrease trauma to children and prevent families from lingering in the system.

Teams are most commonly made up of professionals from CPS, law enforcement, and the prosecuting attorney's office. Other members of the team may include child care agency workers, physicians, mental health workers, psychiatrists, psychologists, guardians ad litem, court-appointed special advocates (CASAs), and representatives from education and public health. (Guardians ad litem and CASAs are discussed later in this section.) Some of these members will meet on a regular basis while others may serve in a less intensive manner (Kolbo & Strong, 1997). Professionals can use the information from these meetings for conducting investigations, writing treatment plans, advising, providing services, educating the community, and monitoring cases. The intent of such teams is to improve collaboration among the professionals and improve services to children and their families (Newman, Dannenfelser, & Pendleton, 2005).

Child Advocacy Centers

As a model of MDT, child advocacy centers (CACs) are places that provide a "comprehensive, culturally competent, multidisciplinary team response to allegations of child abuse in a dedicated, child-friendly setting" (National Children's Alliance, 2003, p. xx; Newman et al., 2005, pp. 165–166). The first CAC was opened in 1985 in Huntsville, Alabama. Since then, almost every state has opened a CAC staffed with social workers.

At the CAC, a trained staff member conducts an investigative interview with the child in a friendly, nonthreatening environment. Interviews are videotaped and, if the child gives permission, other professionals can observe through a one-way mirror. Near the close of the session, which lasts about 45 minutes, team members may request that the interviewer ask the child specific questions (Wolfteich & Loggins, 2007).

Among other services, CACs can also conduct a sexual assault forensic exam (SAFE) on site. These comprehensive, noninvasive physical exams are used to determine if injury has occurred as a result of abuse. The results may be used in court to advocate for the child's protection and/or to prosecute the perpetrator. A doctor or nurse practitioner conducts the exam with a nurse present. The

actual exam takes about 10 minutes; however, time is taken beforehand to develop rapport with the child. A child is not restrained and is not required to complete the exam if he or she wishes not to. The utilization of CACs as "one-stop shops" for gathering information from abused children reduces their stress and increases efficiency within the agencies (Wolfteich & Loggins, 2007, p. 334).

Guardians No. Litem

The Child Abuse Prevention and Treatment Act (CAPTA) provides for the appointment of a **guardian ad litem** (GAL) to represent the "best interests of the child" (Leung, 1996). Initially, lack of specificity resulted in confusion as to the qualifications of individuals fulfilling this role. However, in 1981, attorneys formed Independent Representation for Children in Need (IRCHIN), a nonprofit organization that provides court-appointed GALs to protect the interests of abused children (Head, 1998).

The qualifications for GALs vary by state; some are attorneys, social workers, or specially trained volunteers. GALs represent the "best interest of the child" and ensure that the child's voice is heard in court (Calkins & Millar, 1999). The presence of GALs in the court process is not without challenges. GALs may have their testimony blocked in court proceedings on claims that it is hearsay evidence. Their recommendations can be unrealistic given available resources. GALs may be discharged from a case even when a child remains in an out-of-home placement (Johnson-Weider, 2003).

Court Appointed Special Advocates

In 1977, in Seattle, Washington, Superior Court Judge David Soukup established the **court appointed special advocates** (CASA) program to train volunteers who represent abused children's best interests on behalf of the court (Calkins & Millar, 1999). CASA is a structured program that provides an initial 10- to 40-hour training program for its volunteers on issues related to child abuse, including family dynamics, child witnesses to domestic violence, and child development. CASA volunteer programs are established in all 50 states and volunteers come from all walks of life.

The juvenile court appoints a CASA volunteer to serve as an officer of the court. In that role, the CASA worker visits with the child, investigates the facts of the case, advocates for the child, attends court hearings and team meetings, monitors compliance with court orders, and makes recommendations to the juvenile court on behalf of the child (Leung, 1996; Litzelfelner & Petr, 1997). Among the CASA's principal responsibilities is limiting the number of placements for children and assisting in finding a permanent placement as expeditiously as possible. Unlike GALs, CASA workers do not represent legal opinions, and they are encouraged to stay with the child until permanent placement is obtained; they may stay after permanent placement depending on the legal guardians' wishes (Leung, 1996).

Ostensibly, children in juvenile courts should have workers from GAL, CASA, and CPS who represent their best interests. Each plays a slightly different role. The CPS worker provides assessments and interventions, the GAL assures that the child's legal rights are protected, and the CASA befriends the

child on behalf of the juvenile court. These players can reinforce one another or they can be oppositional. In the final analysis, all these interactions are for the benefit of the child, and they demand teamwork. At the time of the investigative interview with the child, all these individuals have the opportunity to witness, in the child's own words, what happened to him or her (Calkins & Millar, 1999).

Issues in Child Interviewing

The **investigative interviewing** of children is principally forensic in nature, which means the interview is used for court proceedings (Faller, 2007a). The interview also serves to let each professional hear the same story at the same time, thus eliminating the need to question the child repeatedly. The interview is structured and usually happens once only. A skillful investigative interviewer should be neutral and sensitive but not coercive in approaching the child (Faller 2007b).

Social workers are not the only professionals to conduct these interviews; however, their training is excellent for this purpose. Practice and additional specialized training can prepare social workers to assume this responsibility for CACs and other MDTs. A basic requirement for conducting these interviews is knowledge of children's brain development, cognitive development, and the process of memory. These three aspects of cognition can be temporarily or even permanently damaged by the trauma of abuse and neglect (Alessi & Ballard, 2001; Kendall-Tackett, 2000).

According to some experts, the human brain is at its most vulnerable in the first 5 years of life (Kendall-Tacket, 2000, p. 805). Trauma to children during this sensitive developmental time can result in overall generalized problems and lowering of the intellect (Kendall-Tacket, 2000).

The theory of cognitive development is most notably influenced by Jean Piaget's (1954) qualitative explanation of changes associated with cognitive maturation based on four developmental stages (Alessi & Ballard, 2001). From birth to 2 years, children are in the sensorimotor stage; during this time their knowledge of the world is limited to sensory experiences. From 2 to 7 years, children are in the preoperational stage, during which they develop language. During this stage, children do not think logically but rather use their intuition. Although they can remember, their memories are extremely short. Between ages 7 to 11, children are in the concrete operational stage, where life is seen in black and white; they show improved perception but are unable to analyze complex situations. From 11 years of age to adulthood, children are in the formal operational stage, when they begin to view situations analytically (Alessi & Ballard, 2001; Santrock, 2005). This cognitive development coincides with memory and the ability of children to recall facts and verbalize them accurately.

Memory involves encoding, storing, and retrieving information, and there are two basic types (Alessi & Ballard, 2001; Olafson, 2007): **Explicit memory** is how people usually think of memory; it is the ability to recall. **Implicit memory** is from the unconscious mind and is more intuitive. Children are generally truthful; however, the manner in which they perceive the world (owing to their cognitive development) and remember facts (owing to their memory

development) usually results in many inconsistencies. Children are highly suggestible, meaning that their memories are influenced by what adults have told them in the past and their desire to please adults who may be asking questions in the present (Zajac & Hayne, 2003). Children's memory, along with their cognitive development, can be maximized by using empirically proven techniques (Kendall-Tackett, 2000).

One of the techniques for questioning children is referred to as the **stepwise interview** (Yuille, 2002; Yuille, Hunter, Jaffe, & Zaparnick, 1993). First the interviewer establishes rapport using a child-friendly environment with plenty of verbal and nonverbal cues to help the child feel comfortable. Toys, art supplies, puppets, and dolls may be available to help children tell their story, especially for children who have problems verbalizing. The interview is begun using open-ended, neutral statements (about dogs, hobbies, movies) to determine the child's cognitive ability and language skills. The interviewer then focuses on the alleged abuse, still using open-ended (free narrative) questions. More specific, direct questions are then asked. The conclusion of the interview is important, as it leaves an impression with the child. At this point the interviewer thanks the child for sharing information and spending time talking.

The types of questions appropriate for interviewing children suspected of being maltreated are open-ended, such as, "Tell me what happened," and focused, such as "who, what, where, when, and why" (Myers, 1998, p. 124). Types of questions that are inappropriate are specific questions requiring short (yes/no) replies and option-posing questions; also leading questions such as "Isn't it true that . . ." Inappropriate questions tend to make children think that the interviewer is looking for specific answers (Santtila, Korkman, & Sandnabba, 2004; Wood, 2000).

The investigative interviewer does not make comments that would encourage the child to conform to what others have said or to obey authority. The child is not led to believe that specific answers are either correct or incorrect. The child's own terminology for body parts and acts should be used; other terms are not to be introduced. Startled, surprised, disapproving, or related emotional expressions are inappropriate. Reinforcement is not to be given to the child for having given either proper or improper responses. The child must be accepted unconditionally (Faller, 2007b; Santtila et al., 2004)

Determination of the child's truthfulness requires evaluation of physical, verbal, and characteristic (behavioral) evidence. Physical evidence is often missing, as in cases of children who are fondled or exposed to pornography. Verbal evidence is highly accepted, since few children lie or give false statements about being sexually abused (Coulborn-Faller & Corwin, 1995). Characteristic evidence requires a highly trained individual to interpret.

Anatomically Detailed dolls (AD dolls) are not to be used in the investigative interviewing (Santtila et al., 2004). They are more appropriate for clinical use, where they can be used to determine a child's labels for body parts. AD dolls tend to increase negative questions by the interviewer and to decrease unsolicited responses by the child (Faller, 2007c; Santtila et al., 2004). Sexually abused children do not tend to engage in more sexually explicit play with the AD dolls than children who have not been sexually abused; thus their use is best left to professionals specially trained in this area who are using them for treatment purposes (Santtila et al., 2004).

Ideally, when investigative interviews are complete, team members will fulfill their individual responsibilities and collaborate. Social workers' responsibilities include maintaining contact with the various parties, ensuring that the children receive appropriate services, and preparing for court.

Testifying in Court

Not uncommonly, social workers are subpoenaed to testify on behalf of their clients. When called, they consult with their supervisors, clients, and attorneys. If the agency does not have its own legal defense, a private attorney is contacted (Myers, 1998). The Legal Defense Fund of the National Association of Social Workers (NASW) addresses legal issues of the profession, and NASW offers professional insurance, advice, and numerous other resources. Knowing one's rights and responsibilities can protect clients and can also protect against breach of confidentiality.

When an attorney wants a social worker to appear in criminal court, she or he will have the sheriff's office serve a **subpoena,** which is an official court document requiring a person to respond. The subpoena may require them to appear in court to testify or to bring specified records, referred to as *dues tecum* (Myers, 1998, p. 211). Failure to respond to a subpoena is considered contempt of court and is punishable by imprisonment or other means (e.g., a fine), depending on the judge's wishes.

If social workers are to testify, they need to clarify the type of testimony that is expected. **Factual testimony** is the provision of information obtained by seeing, hearing, smelling, or touching and is provided by a lay (nonexpert) witness. For example, when CPS workers are involved in a case that goes to criminal court, they may testify as to the condition of the home, the children, and any other information within their knowledge. **Expert testimony** is provision of information obtained through specialized technical, clinical, or scientific training and information in accordance with the testifier's expertise (Myers, 1998). Social workers can testify as either lay witnesses or expert witnesses, depending on their role in a case.

Before the hearing, the attorney and social worker will meet for a **pretrial conference.** At this conference, they will review the probable questions that will be asked on **direct questioning** (from the prosecuting attorney) and on **cross-examination** (from the defense attorney). They will discuss the strengths and weaknesses of the testimony and perhaps consider the use of charts or other equipment. Social workers should consult with their attorneys about using notes in court, because referring to a part of a document may open the entire document to the court and prove to be detrimental (Myers, 1998).

Before going to trial, the **deposition** takes place. The deposition is held in an office, not in a courtroom. Persons at the deposition are attorneys and a court reporter. No judge or jury members are present—that is, no one who makes the final decision as to "guilt" or "innocence" is present. Testimony is provided under oath and may later be used to show any inconsistencies between statements made at the pretrial deposition and the court proceeding (Myers, 1998). Testimony is to be given in the same manner that it will be given in court. The deposition is not a trial run but a discovery of evidence for both sides of the case.

Some basic rules apply to social workers appearing in court; many of these rules would apply to any professional (Vogelsang, 2001).

- Tell the truth.
- Listen to the whole question before answering. Do not give an answer until the question is understood.
- If the attorney's question is not understood or not heard, ask the attorney to repeat the question or state that you do not understand.
- Answer only the question that is asked. Answer directly and simply. Do not volunteer information not actually asked for.
- If an attorney asks a "yes or no" type of question but the answer is not that simple, the reply may entail more. Give the answer in your own words.
- If the prosecuting attorney objects to the testimony being given, stop talking immediately. Do not answer until instructed. If the judge "overrules" an objection, answer the question. If the judge "sustains" an objection, do not answer the question.
- Give positive, definite answers when at all possible. Avoid saying, "I think" or "I believe."
- If an attorney asks something that was once known but is forgotten, the reply is "I do not remember." If the incident was never known, the reply is "I do not know."
- If a technical word is used, explain it in lay terms.
- Be professional, confident, and respectful.
- Do not get emotional.
- Look at the jury when answering.
- Remember that defense attorneys try to discredit witnesses; they're doing their job (Vogelsang, 2001).

As a lay witness of factual information, social workers are not entitled to receive compensation for lost income while they are in court. They are eligible for whatever specified fees and transportation reimbursements the court provides to all witnesses. Social workers in private practice who testify at the request of a client may be able to request reimbursement; this must be discussed with the client.

Social workers face special issues when testifying as expert witnesses; this is discussed in the following sections.

Expert Witnesses

Expert witnesses can serve in a treating or forensic role (*treating* meaning providing counseling and other services; *forensic* meaning testifying in court). However, ethical principles advise against a social worker acting in both roles for the same case, especially in child maltreatment cases, because the roles conflict with one another (Myers, 1998). Treating witnesses testify on issues such as the diagnosis, care, prognosis, and responses of patients. Forensic witnesses testify on issues such as the awarding of child custody, determination of sanity, or commitment to a mental institution.

Expert testimony provides information that is not considered common knowledge (Berliner, 1998). In child maltreatment cases, such testimony tends

to involve issues such as the characteristics of abuse, behaviors commonly observed in abused children, and profiles of abused children and perpetrators. Testimony can dispel myths and must be relevant (i.e., related to the contested issue), be accepted in the scientific community of the professional's particular field, and add to jurors' understanding of the case (Myers, 1998).

Some types of testimony are particularly controversial in court. One is testimony provided as **substantive evidence**, which is to suggest that the child is acting *as if* he or she were maltreated, which is similar to stating that the child is in actuality maltreated (Berliner, 1998). Another is **child sexual abuse accommodation syndrome** (CSAAS; Berliner, 1998, p. 17). CSAAS was at one time used to explain the behavior of sexually abused children who reacted differently than laypersons might expect them to (e.g., they did not reveal the abuse, were submissive, retracted the accusation, or were inconsistent). The word *syndrome* was problematic because it means a "medical condition," and the courts misused the term to the point of being detrimental to the testimony (Alexander, 1995; Berliner, 1998).

Other types of testimony have proven less controversial and often helpful in supporting the child's position. The expert witness can provide testimony that is educational to the jury in understanding the child's cognitive processes and emotional reactions. He or she can provide information that help attorneys, judges, and jurors understand issues in an increasingly complex world (Foot, Stolberg, & Shepherd, 2000; Myers, 1998).

Expert witnesses require the knowledge, skills, experience, training, and education to assist the court in understanding the case. The prosecuting attorney (in evidentiary proceedings) will try to establish the expert witness' credibility in the eyes of the jury, and the defense attorney (in adversarial proceedings) will attempt to raise doubt. Credibility is established through the expert witness' expertise, honesty, objectivity, and presentation (Foot et al., 2000; Siegel, 2008). To become expert witnesses, social workers must be expert clinicians, seek experienced mentorship, read legal cases and transcripts, and practice in moot courts (Pruett & Solnit, 1998). The development of expertise takes time and practice.

Testifying in court can be an uncomfortable and intimidating procedure for many adults, and, as discussed in the following, it can be even more difficult for children.

Children as Witnesses

The child maltreatment cases that are tried in criminal courts typically involve allegations of physical and sexual abuse (Sedlak et al., 2005). Historically, child abuse victims who come to court tend to be revictimized by a system that is insensitive and nonresponsive—one that "seesaws" between leniency for the perpetrator and leniency for the victim (Carr, 2007).

Until the 1970s, children were subjected to the same courtroom process and procedures as adults, including cross-examination (Bala, Lee, & McNamara, 2001). One of the first questions they would be asked to answer concerned their ability to tell the difference between the "truth" and a "lie." Judges would question them about their understanding of the "duty to speak the truth" and the "nature and consequences" of an oath, in an effort to make sure that

they understood the gravity of the charges (Bala et al., 2001, p. 43). They had to tell every detail of their abuse in an open court and in front of the person who abused them. On cross-examination, attorneys would often try to confuse and intimidate the children with their questions (Bala et al., 2001).

Changes in the courtroom experiences for children coincided with the women's movement. Women who were raped were typically hesitant to go to court because the experience was humiliating. They had to reveal not only the graphic details of their rape but also the history of every man with whom they ever had an intimate relationship (Bala et al., 2001). As victim's advocates began questioning these practices, courts began to change their procedures.

Similarly, abused children were also exposed to a courtroom environment in which they had to tell their stories in front of the judge, jury, and defendant. In an advocacy effort for children, researchers increased their studies of the courtroom setting and its effect on children's testimony (Bala et al., 2001). They found numerous reasons why children had difficulty telling their stories in court.

Children, even very young ones, can have accurate memories; however, children, especially those below 10 years of age, are highly suggestible. Traumatized children in particular find free recall of events difficult; they are deferent to adults' beliefs, and they easily become confused and have difficulty in accurately communicating past events (Olafson, 2007). The negative impact is due to factors associated with the abuse itself, such as the stigma, blame, and secrecy; the betrayal; and the powerlessness. They may be unable to control their situation or to make others believe them (Westcott & Page, 2002). Further hampering accurate testimony is the child's self-image, with its insecurity; coping mechanisms, including denial and avoidance; emotions of fear and embarrassment; stress through intimidation; and anxiety (Nathanson & Saywitz, 2003; Sheehan, 2003).

The courtroom setting increases children's stress through its confusing environment, which includes a multitude of players, unusual language, and most notably the experience of being cross-examined (Sheehan, 2003; Westcott & Page, 2002). Children's high level of suggestibility enables questioning parties to confuse them (Sheehan, 2003; Zajac & Hayne, 2003). Abused children are in an unequal power position with the defense attorney, just as they were with their abusers (Doherty-Sneedon & McAuley, 2000; Sheehan, 2003; Zajac & Hayne, 2003).

Changes are taking place in the courtroom process to reduce children's trauma from the experience of having to testify. Courts have been more lenient in determining children's competency to testify. Some courts are allowing closed-circuit televising of children's testimony, which reduces the stress placed on the child. The legality of closed-circuit televising is a source of contention for several reasons. For one, the accused cannot cross-examine the accuser. Other problems with closed-circuit television are its effects on the jury and judge. They are unable to see the child's gestures and to hear all parts of the testimony (Doherty-Sneedon & McAuley, 2000).

Some courts have developed programs to introduce children to the courtroom experience prior to their testimony. Children are introduced to the judge, bailiff, court reporter, and attorney. They are able to see where the jury sits; to sit in the witness chair, where they are questioned about neutral issues (noth-

ing to do with their case); and educated on the procedures that will take place (Doueck, Weston, Filbert, Beekhuis, & Redlich, 1997).

Another way to make court procedures more favorable to children is to allow hearsay evidence. For instance, a child may have told a CPS worker about the abuse and who inflicted the injuries. Were the CPS worker to testify in court as to the child's words, the testimony would be considered hearsay. Allowing this type of testimony can strengthen the evidence on behalf of the child and against the defendant.

However in 2004, in the case of *Crawford* v. *Washington*, the Supreme Court supported defendants' right to be confronted by their accusers, in accordance with the sixth amendment of the U.S. Constitution (Carr, 2007). This decision, in particular, has caused hearsay evidence to be highly challenged. Some hearsay evidence is admissible under certain circumstances, such as "excited utterances" (statements made in a state of emotional startle) and medical diagnosis.

Videotaping is another method that is used to reduce trauma for children. Videotaping, such as that done at CACs, enables the child to discuss the abuse in a safe location with a trained interviewer. Showing the tape in court may not be allowed; a common argument against it is that the defense attorney has not had a chance for cross-examination (Carr, 2007). Videotaping with both attorneys present remains a viable possibility for enabling the child to forego the trauma of the courtroom. However, there is evidence that juries tend to believe live testimony over televised testimony (Nathanson & Saywitz, 2003).

More must be done to make the courtroom a place where abused children can receive justice. Innovative and child-sensitive techniques are needed to encourage children to remember and to testify truthfully while at the same time reducing their stress and anxiety. Children need social support to buttress their emotional health during this stressful experience. The courtroom environment must be more child-friendly and less formal. Defense attorneys must adopt strategies for questioning that are age-appropriate and less threatening (Nathanson & Saywitz, 2003; Sheehan, 2003; Zajac & Hayne, 2003). For justice to be served, the less powerful require opportunities to become more powerful.

Summary

The three government branches (executive, legislative, and judicial) have established statutes, policies, and laws on behalf of children and their families. The judicial system, as applicable to child maltreatment, is divided between juvenile and criminal courts. Differences between the courts include their purpose (protection of children versus charges against adult perpetrators) and standards of proof. Social workers are important participants in both types of hearings and are responsible for having a working knowledge of these proceedings.

All members of the child welfare system are responsible for protecting children and helping families. The Child Advocacy Center is one type of multidisciplinary team (MDT) established to assist in collaboration among the various professionals and laypersons for this purpose. Specialized services to assist children in court proceedings are provided through guardians ad litem and court appointed special advocates (CASAs).

A court procedure can be an uncomfortable experience for adults, including social workers, and a terrifying experience for children. Children's cognitive and emotional immaturity often proves detrimental to their ability to testify. Social workers and all others who work with children must be aware of their developmental needs and must take advantage of all resources to make the courtroom experience as easy as possible for them.

Trial Ahead for Ex-Foster Father Accused of Abuse

A former foster father accused of having sex with two of his three adopted daughters is on his way to a trial.

Christian County Associate Circuit Judge John Waters Thursday found probable cause for each of the nine felony charges filed against Christopher Gray, 39.

The Nixa man faces six counts of statutory sodomy, two counts of statutory rape and one count of sexual exploitation of a minor.

Gray will be arraigned on Sept. 3 in the Christian County Circuit Court.

Dressed in a light-blue shirt with thin stripes and a dark blue tie, Gray appeared in Waters' courtroom Thursday afternoon with his attorney Dee Wampler.

The Springfield defense lawyer began the hearing—which lasted more than four hours—by filing three motions: one to dismiss the charges, one for discovery and one to disclose impeaching information.

Waters overruled all three motions.

Wampler then asked for a gag order, which would prevent all parties involved in the case from releasing information to the media outside the courtroom.

Waters granted the request before Christian County Prosecuting Attorney Ron Cleek proceeded to present evidence and call upon his witnesses—including the two girls with whom Gray allegedly had sex.

The younger girl, age 6, however, did not testify against Gray.

"No, I don't know," the girl said repeatedly when she was asked by Cleek whether Gray had ever touched her inappropriately.

The 6-year-old was barely taller than the witness stand and kept her head low.

But the older girl, age 11, provided testimony against Gray.

She told the court that Gray had sex with her "numerous" times, that he had repeatedly touched her during the four years she lived with him and that Gray had threatened her not to tell anyone else.

The girl said that Maya Gasa, Gray's live-in girlfriend, was engaged in sexual behaviors with her as well. Gasa, 28, faces one count of statutory sodomy in a separate case. Her preliminary hearing has been postponed to Sept. 8. Cleek has said he intends to file more charges against her.

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The 11-year-old also testified that she was in a home video, which Cleek described as pornographic.

The video, which a police officer said was seized from Gray's home during a search, was shown in the court, but the video monitor was positioned so that only the judge, the defending party, the prosecuting attorney and the person on the witness stand could view it.

Other witnesses were Barb Hilton, a therapist at the Community Counseling Center in Nixa; Kathy Bernet, an interviewer at the Child Advocacy Center in Springfield; and Don Jones, a Nixa Police officer.

Hilton, who has been working with the 6-year-old girl, said the child has been traumatized and may have a memory blockage.

Bernet, who interviewed the 6-year-old, explained the techniques she used in talking to the girl before their taped interview was replayed in the court.

In the 45-minute interview, the youngster told Bernet that Gray had sex with her.

With a grim look on his face, Gray did not speak during the hearing. Instead, he whispered to Wampler from time to time, and sometimes he shook his head at some allegations.

Wampler attempted to cast doubts on the veracity of the evidence.

He argued that the tape, which allegedly was seized from Gray's home, could have been tampered with because police officers other than Jones could have accessed it.

In cross-examining Hilton, Wampler suggested that the younger girl could have been traumatized by someone other than Gray.

The defense attorney also noted the younger girl had given inconsistent answers in the taped interview.

And Wampler questioned the soft smiles on the older girl's face during her testimony.

"You were smiling at Ron (Cleek)," Wampler said to the older girl.

"It's irrelevant," the judge said.

"I have my theory," Wampler said. "A man could face a life sentence with state corrections, and maybe someone is not taking this seriously."

The judge was not persuaded.

"I see nothing inappropriate," Waters said.

And there were some light moments during the tense hearing.

Cleek didn't realize the seized tape was a VHS format until he was about to show it. He asked Waters to switch to other charges against Gray while he could obtain a different player to show the tape.

Wampler immediately filed a motion for dismissal, arguing the prosecuting attorney was ill-prepared for the preliminary hearing.

"It's his case," Wampler said. "And he's not prepared."

The judge, however, granted Cleek's request and overruled Wampler's motion.

A few minutes later, Wampler had technical difficulties of his own when his tape recorder apparently was not functioning.

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"Technology is great when it works," Cleek said to Wampler.

Waters came to Wampler's rescue when he gave the defense attorney some batteries.

"Technology fails you, too?" the judge said. (Tang, 2004)

—By Didi Tang published in the *Springfield News-Leader* (MO) on August 13, 2007.

Discussion Questions

1. How many times would the girls (in the Gray story) need to testify if the Child Advocacy Center were not available?
2. Imagine that you are a CPS worker assigned to work with Christopher Gray. All social work students are taught the "conscious use of self." How would you, as a CPS worker, employ the "conscious use of self" in separating personal from professional thoughts and emotions in working with the children and foster father in the Gray case? How feasible is this separation of the "personal" from the "professional"?
3. As a CPS worker, what would be your treatment plan for these two girls after the foster father surrendered custody?
4. In your opinion, what does the future hold for these girls? How can their future be improved?
5. What recommendation could you make to ease the trauma of these girls rather than their having to testify and give their stories over and over again?
6. What is your opinion as to the quality of the media coverage of the story as demonstrated by the two articles reprinted in this chapter?

Key Terms

Adjudication hearing
Allegations
Anatomically Detailed dolls
Child advocacy centers (CACs)
Child protection teams (CPTs)
Child sexual abuse accommodation syndrome (CSAAS)
Civil courts
Common laws
Complainant
Court appointed special advocates (CASA)

Court decisions
Criminal courts
Cross-examination
Defendant
Deposition
Detention hearing
Direct questioning
Dispositional hearing
Documentary evidence
Excited utterances
Expert testimony
Expert witness
Explicit memory
Factual testimony
Family courts
Guardian ad litem (GAL)
Hearsay evidence
Implicit memory
Investigative interviewing
Juvenile courts
Laws
Multidisciplinary teams (MDTs)
Parens patriae
Permanency plan
Petition
Preponderance of evidence
Pretrial conference
Real evidence
Regulations
State-of-mind exception
Statutes
Stepwise interview
Subpoena
Substantive evidence
Testimonials

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Consequences of Child Maltreatment and Continuum of Care

5

Turnaround Tykes Therapeutic Preschool Gives Abused and Neglected Children a Chance to Heal

Before he got kicked out of school twice, William had been addicted to cocaine, abused, neglected and abandoned—but this was no teenager.

Just a scant over 3 feet tall, he had yet to turn 4.

William was on his way to a life in the foster care system because of his early trauma and wild behavior.

His aunt, Andrea Eldridge, wanted to keep him. She was a sober survivor in a family broken by cocaine, and William's mother was unable to care for him.

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When William—who bit and cursed and ran and kicked—was asked to leave another day care after just three days there, Eldridge doubted she could take him in.

"I thought, Lord God this child is a monster," she said.

Then, one year ago, a door opened for William.

It was heavy and metal and located at the back of the lobby of the St. Louis-based Family Resource Center. Beneath a drawing of a brown belt crossed out with a red line, the door bore a message: There are no "whuppings" at this school.

William became one of about 1,200 abused and neglected children from St. Louis to enter the safe haven of the Center's Therapeutic Preschool, a 35-year-old child care center that gives the youngest victims of physical abuse, sexual violence and neglect a chance to heal and become little kids again.

At this preschool, nobody gets kicked out. The children learn to manage their extreme behaviors so they can one day go to kindergarten, sit still at a tiny desk, learn to read and have a chance at a future. For many like William, it means the difference between a permanent childhood home or institutionalized care in state custody.

"William was a child that was enraged," said Director Velma Bell as the class of 4- and 5-year-olds sat cross-legged around a blue rug. "A lot of that had to do with his grief about his mother and his abandonment, and his longing for his mother." (Cambria, 2009)

—Reprinted from the February 27, 2009, issue of the *St. Louis Post-Dispatch* (MO).

Violent behaviors are learned early in life. Children who are abused often eventually pass those behaviors to the next generation. The consequences of child maltreatment are multifaceted and complex and include physical, emotional, cognitive, and social factors. This chapter delves into the symptoms of and consequences to childhood victims of abusive behaviors.

Beyond the personal costs to the victims of child maltreatment, there is a financial toll to society. Interventions by child welfare, law enforcement, and health care systems are estimated at $24 billion annually (*Long-Term Consequences of child abuse and neglect*, 2006). In the long term, the costs of child maltreatment are incalculable in terms of individual, family, and social suffering.

Many of these symptoms and consequences can be averted or mitigated with assistance of services from the child welfare system. Children and their families have an array of in-home services from which to choose, and, when children must be removed from their own homes for their own safety, various out-of-home placements are available for filling this essential gap of support. This labyrinth of services is fraught with challenges that call for social workers to unravel and resolve.

Consequences of Child Maltreatment

As a result of abuse and neglect, children may suffer both short- and long-term consequences, which are reflected through various symptoms (indicators). These symptoms and consequences can be categorized by three different perspectives: (a) the type of abuse experienced (e.g., sexual, physical, neglect, or emotional); (b) the age of the child at the time of intervention (e.g., infant, toddler, school age, or teenage); and (c) the major maladaptive behaviors exhibited (e.g., neurological, physical, emotional, or cognitive). Although these perspectives are helpful for discussion purposes, the symptoms of abuse are not so clearly distinct from one another (Mabanglo, 2002).

Symptoms by Types of Abuse

The effects on children's lives can be partly determined by the type of maltreatment children suffer. In many cases, children suffer **polyvictimization,** which means they have experienced more than one type of maltreatment; thus, their chances of suffering adverse consequences are increased (Finkelhor, Ormrod, & Turner, 2007).

In cases of sexual abuse, symptoms are more accurately analyzed by knowing the exact type(s) of abuse (such as penetration or exposure to pornography), its frequency, and its severity. Considered severe are those cases that are chronic and involve violence; however, differentiating the severity of sexual abuse is subjective rather than empirical (Paolucci, Genius, & Violato, 2001). The extent of damage can "include posttraumatic stress disorder (PTSD), depression, suicide, sexual promiscuity, victim–perpetrator cycle, and poor academic achievement" (Paolucci et al., 2001, para. 3).

Physically abused children may suffer personality disorders, become aggressive, experience health problems, and fail to develop adequate academic skills (Thompson, Kingree, & Desai, 2004). The child's gender can be a factor. Men who were physically abused as boys have been more likely to sustain serious injuries in adulthood and to abuse alcohol; whereas women who were abused as girls tend to show more physical and mental health disorders and to abuse prescribed medications such as tranquilizers (Thompson et al., 2004).

Emotional abuse has been referred to as the "core issue" in child abuse and neglect, which suggests that this type of abuse is characteristic of all types of child maltreatment (Hart & Brassard, 1987). Although emotional abuse does occur in combination with other types, this type of maltreatment occurs separately and needs to be studied separately to assist in its detection and treatment (Jellen, McCarroll, & Thayer, 2001). Emotional abuse is lacking in research, commonality of definition, and understanding (Behl, Conyngham, & May, 2003; Jellen et al., 2001; Thompson & Kaplan, 1999). These shortcomings may be because child physical abuse and sexual abuse are more easily operationalized (defined) and because of the misconceptions that these other types of abuse have more negative outcomes than does emotional abuse (Behl et al., 2003).

Broadly stated, emotional abuse is "failure to provide adequate emotional care to children" (Thompson & Kaplan, 1999, p. 192). "According to the study of Garbarino, Guttmann, and Seeley emotional abuse (psychological maltreatment)

takes five forms: rejecting, isolating, terrorizing, ignoring, and corrupting" (Jellen et al., 2001, p. 624). Emotional abuse can be passive (acts of omission), such as being emotionally unavailable or showing lack of respect, or active (acts of commission), such as rejecting and verbally degrading the child (Glasser, 1995, 2002; Iwaniec, 1995; Iwaniec, Larkin, & Higgins, 2006; Thompson & Kaplan, 1999). "According to Hart, Germain, and Brassard the consequences of these acts damage immediately or ultimately the behavioral, cognitive, affective, social, and psychological functioning of the child" (Thompson & Kaplan, 1999, p. 192). Emotionally abused children have shown problematic cognitive and educational outcomes, such as disruptive behaviors and failure to be promoted; social and behavioral outcomes, such as being overly compliant or disruptive; physical and health outcomes, such as being hyperactive or overly anxious; and interpersonal and mental health difficulties, such as having low self-esteem and mood disorders (Iwaniec et al., 2006).

Neglect means failing to provide for a child's basic needs, including physical (food and shelter); medical (physical and mental health care); educational (attending school); and emotional (supervision; Rodriguez-Srednicki & Twaite, 2004a). Neglectful acts come in numerous forms, such as abandonment of the child, a hazardous living environment, lack of attention to the child's hygiene, and allowing the child to be truant (Rodriguez-Srednicki & Twaite, 2004b).

Failure to thrive (FTT) is one type of neglect in which infants suffer from a nonorganic deceleration in their rate of growth, usually caused by the parent's refusal or cognitive inability to care for the child (Kerr, Black, & Krishnakumar, 2000). At least 5% to 10% of infants tend to suffer from FTT (Kerr et al., 2000, p. 588). As with other types of neglect, the results of this can continue throughout adulthood and have been associated with low self-esteem and being positive for HIV-related risk behaviors (Klein, Elifson, & Sterk, 2007).

Despite such outcomes, neglect tends to be overlooked as a serious type of child maltreatment; this oversight is referred to as "neglect of neglect" (Krugman & Kempe, 1997, p. ix). Children who suffer from neglect may become involved in gangs, use drugs, have sexual encounters, and commit criminal activities (Cantwell, 1997). As adults they tend to evidence poor self-control, a short attention span, depression, and aggression (Rodriguez-Srednicki & Twaite, 2004b).

Symptoms by Age at Time of Intervention

Even in their prenatal development, children can be abused. The offspring of pregnant women who use alcohol and illicit substances during pregnancy may experience a lifetime of medical and social issues (Brown & Bednar, 2004). Pregnant women's excessive use of alcohol can result in **fetal alcohol effect** (FAE) and **fetal alcohol syndrome** (FAS); both may leave children with permanent birth defects that affect their central nervous systems and result in cognitive and functional disabilities (including attention deficits), secondary disabilities (e.g., mental health problems), and mental retardation (Streissguth, 2001). Pregnant women's use of illicit drugs can result in their newborns undergoing withdrawal-like symptoms including breathing problems, continual crying, and seizures as well as experiencing a lifetime of medical, learning, and behavioral problems (Kuperman, Schlosser, Lidral, & Reich, 1999). As children

mature, they continue to present challenges through mood swings, impulsive behaviors, learning disabilities, and hospitalizations (Moss, Baron, Hardie, & Vanyukov, 2001; Peleg-Oren & Teichman, 2006).

Infants and young children (under 3 years of age) remain "overrepresented in substantiated cases of abuse and neglect . . . [the] overall child victimization rate was approximately 1.25 percent, [and] the rate for children younger than three was 1.64 percent, which is about 184,000 children [in 2003]" (Herman, 2007, p. 18). Young children are extremely demanding on parents, which makes them particularly vulnerable to parental abuse. In frustration and anger, especially to infants' crying, parents may shake or strike their infants (Showers, 1992; Stipanicic, Nolin, Fortin, & Gobeil, 2008). The force of shaking can result in whiplash, referred to as **shaken baby syndrome** (SBS), which is often fatal (Krugman, 1985). According to Rudolph (as cited in Gill et al., 2009, p. 619), "Because it is often difficult to be certain whether intracranial bleeding is due to shaking and/or impact, the term shaken baby has been replaced with shaken baby/impact syndrome." A strike to infants and young children can result in head trauma, which is the main cause of fatal abuse in young children, and in trauma to the abdomen, which is the second principal cause of death (Gill et al., 2009).

Abused preschoolers (3 to 5 years of age) may show poor skills in interacting with peers and maintaining self-control, as displayed through excessive withdrawal or aggressive behaviors (Darwish, Esquivel, Houtz, & Alfonso, 2001). Harm at this age interferes with interpersonal skills that are highly related to social and psychological difficulties and various physical problems in adulthood (Darwish et al., 2001). These children are unsure of themselves, self-conscious, and without self-esteem. They are unable to play with their peers and thus unable to form important relationships (Darwish et al., 2001).

School-age children (6 to 12 years of age) experiencing abuse often show poor academic competence and an inability to estimate their own competence because of their low self-worth (Kinard, 2001). The lack of skills from their earlier years results in additional misbehaviors or withdrawals. Commonly, abused children, especially boys, will abuse animals. These acts are disturbing, illegal, and antisocial; they are highly related to violence within the family (Flynn, 2000; Long, Long, & Kulkarni, 2007).

Adolescents who experienced abuse during their childhood tend to suffer depressive symptoms. They are unable to concentrate, have disturbed sleeping patterns, and suffer feelings of worthlessness. These adolescents tend to have behavioral and emotional problems, which they manifest in self-mutilation, suicide attempts, and suicidal ideation (Westenberg & Garnefski, 2003). Abused adolescents, commonly, run away from home to escape further abuse; however, their homelessness leaves them vulnerable to delinquency and further victimization (Kim, Tajima, Herrenkohl, & Huang, 2009).

Symptoms Exhibited by Maltreated Children

Maltreated children may manifest neurobiological, physical, and/or emotional difficulties that require intervention. The mind and body are so inextricably interwoven that to address one without the other may be futile. A gestalt view takes all parts of the child's life into consideration.

Neurobiological and Cognitive Symptoms

During the 1990s, called the "decade of the brain" (Kendall-Tackett, 2000, p. 799), a wealth of research focused on the impact of child abuse on the brain's development (see, for example, Azmitia, 2001; Lee & Hoaken, 2007; Wasserman, 2007). When pre–school-age children are abused and neglected, the trauma can result in a "rewiring" of their brains. Especially during certain critical periods of development, trauma affects the neural system, which, in turn, results in children's maladaptive emotional, behavioral, and cognitive functioning as they mature into adults (Kendall-Tackett, 2000).

Neuroimaging techniques measure the structural changes to the central nervous system (CNS) and functional neural activity patterns (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006). Examples of these techniques are *magnetic resonance imaging* (MRI) and *positron emission tomography* (PET). The PET scans "result from the detection of radiation from the emission of positrons, which are tiny particles emitted from a radioactive substance administered to the patient" (Watts-English et al., 2006, p. 724). With modern techniques and increased knowledge of the functioning of the brain, the effects of child abuse as a type of traumatic event can be seen within the brain.

Kendall-Tackett (2000) researched the functioning of the brain as influenced by severe trauma, with the intent of increasing the awareness of other researchers to the physiological aspects of studying child abuse. "Chronic hyperarousal is an abnormal state of activation that occurs in the wake of traumatic or highly stressful events" (Kendall-Tackett, 2000, p. 800). Past researchers, such as Yehuda (1998) and Bremner (1999), found that chronic hyperarousal is manifested in abnormal levels of stress hormones within the brain, including norephinephrine and cortisol, and can alter brain structures.

Two co-occurring sequelae of chronic hyperarousal are posttraumatic stress disorder (PTSD) and depression. According to Rutter and Rutter (as cited in Kendall-Tackett, 2000, p. 805), traumatic events can result in permanent changes within the brain, which may be "as serious as actual loss of brain substance . . . [taking] into account 'neural plasticity,' where parts of the brain may take over the functions normally performed by damaged sections." The authors concluded that treatment for symptoms of child abuse requires a holistic approach that address both the mind and body of victims of child abuse.

Azmitia (2001) reported the impact of alcohol and other drugs on the brain during the five stages of the life cycle. One of these stages is pregnancy, during which the fetus can experience the negative effects of substances consumed by the mother. Consumption of alcohol and other substances affects neurotransmitters within the brain, including glycine, glutamate, serotonin and dopamine. Zuckerman et al. (as cited in Azmitia, 2001, p. 48) have pointed out that babies exposed prenatally to cocaine "('crack babies') are at risk for premature birth, low birth weight and smaller head circumference." The maternal ingestion of alcohol during pregnancy can abort a fetus. If the child lives, he or she is at risk for mental retardation, excessive crying, and developmental delays in motor, cognitive, and social skills (Azmitia, 2001, p. 49).

"Although the majority of brain development takes place before the first five years of life, brain structures and synaptic 'pruning' away of relatively inactive neurons continue to develop throughout middle childhood and adoles-

cence" (Lee & Hoaken, 2007). The structure of the brain is *plastic,* meaning it can change. As individuals mature, their brains become *neuroplastic,* which enables neurons to be in constant flux and changeable (Azmitia, 2001, p. 42). People use 100% of their brain cells, not 10%, which must stay active to sustain life (Azmitia, 2001). There are windows of opportunity during which the individual can competently learn certain tasks, such as the period between 12 to 36 months of age (Wasserman, 2007).

Child abuse affects the structure and function of the brain (as well as having psychological impacts). As abused children mature, they are unable to concentrate on their studies, and their language skills are not as well developed as those of other children (Lee & Hoaken, 2007). Poor performance may lead to negative reactions from teachers and/or peers, which in turn can result in social isolation or aggression toward others (Lee & Hoaken, 2007).

Physical Symptoms

Victims of abuse may have disturbed sleep, loss of appetite, headaches, and stomach aches (Avery, Rippey-Massat, & Lundy, 2000; Forbey, Ben-Porath, & Davis, 2000). Sexually abused children may become sexually promiscuous and have suicidal ideation, reflected in self-harm and risky behaviors (Kim et al., 2009; Paolucci et al., 2001). Consequences may include substance abuse, aggression toward other children, and abuse to animals (Long et al., 2007; Thompson et al., 2004).

Emotional Symptoms

Victims of child maltreatment may demonstrate symptoms of **post-traumatic stress disorder** (PTSD) including easy arousal, avoidance behaviors, numbing of feelings, and physical problems (Kendall-Tackett, 2000; Westenberg & Garnefski, 2003). Victims may exhibit pervasive unhappiness, poor self-esteem, anger, depression, and aggression (Westenberg & Garnefski, 2003).

Because of the multifaceted symptoms and detrimental effects of maltreatment, expertise from an interdisciplinary team can provide the most effective interventions (English, 1998). The family health perspective, introduced in Chapter 1, provides a foundation for this problem-solving intervention, with its focus on the seven different components of health (physical, emotional, psychological, spiritual, social, financial, and cultural). A team of social workers, physicians, psychologists, educators, law enforcement officers, and attorneys are among the professionals who collaborate during the assessment, planning, and intervention processes. This interdisciplinary collaboration is in keeping with the National Association of Social Workers' Code of Ethics (National Association of Social Workers, 2008, Standard 2.03).

Children With Special Needs

Children with special needs tend to experience more abuse than other children (Herman, 2007). *Special needs* may refer to children with physical or mental disabilities, conditions such as Down's syndrome, failure to thrive (Kerr & Black, 1999), and/or severe mental illness (Shahar, Chinman, Sells, & Davidson,

2003). The abuse may precede the disability, or it may be a by-product of such children's demands on parental time and resources. Children with disabilities require additional attention for determination of past abuse and prevention of future maltreatment.

Intergenerational Violence

A long-term consequence of child maltreatment is the higher likelihood of **intergenerational violence** (Hurley & Jaffe, 1999). Violence is a learned behavior that is passed down from parents to their children. Women who were abused (as children and/or adults) are at an increased risk to abuse their children (Craig & Spring, 2007). Women who were sexually abused as children tend to have children who become victims of sexual and physical abuse (Avery, Hutchinson, & Whitaker, 2002). Adolescent boys who are victims of abuse may resort to aggressive behaviors, including delinquency and domestic violence (Wolak & Finkelhor, 1998).

Resilience in Victims of Violence

Not all maltreated children are destined to continue the cycle of intergenerational violence. Many children can demonstrate **resilience** despite the maltreatment. As a theoretical approach or perspective, resilience is the antithesis of the disease model (Henry, 2001). The disease model of psychopathology focuses on "symptoms, classification, prognosis, treatments, and risk factors" (Henry, 2001, p. 285). The resilience model utilizes a "positive approach, identifying strengths in individuals, and providing a basis for collaborative problem solving and empowerment of the individual" (Henry, 2001, p. 285).

Resilient children develop coping strategies for dealing with the abuse (Henry, 2001). Their resilience is usually attributed to the influence of an important figure in their lives (Muller, Goebel-Fabbri, Diamond, & Dinklage, 2000). This figure can be a nonabusive parent, sibling, peer, teacher, or another responsive adult (e.g., grandparent or other relative). These figures provide some protection from the effects of the maltreatment by giving the child a sense of self, a feeling of being loved, and a sense of being worthy of affection (Henry, 2001).

Services for Maltreated Children

The **child welfare system** is a collaborative enterprise of community and governmental entities established on behalf of families. Child welfare agencies within this system share the goal of promoting the safety, permanency, and well-being of society's youngest members. In general, most child welfare agencies hold that the best placement for children is with their parents provided that the environment is healthy and free from abuse (Okagbue-Reaves, 2005). Whether a child is able to remain in his or her home or requires an alternative home, various placement alternatives are available. Social workers are involved in all types of service provision, including the in-home and out-of-home alternatives discussed in the following sections.

In-Home Care Alternatives

Family centered services are available in many communities and provide many opportunities to strengthen family bonds and improve childhood development. Providers include YMCAs, Boys' and Girls' Clubs, Girl and Boy Scouts, neighborhood associations, civic groups, and a myriad of other civic organizations.

Family support services provide prevention and early intervention to families to help them solve problems. These community-based services include early developmental screenings, parent education, early childhood development, child care, family resource centers, school-linked services, recreation, and job training. Respite care may be provided to families, which gives the caregivers short breaks from their children (Doig, McLennan, & Urichuk, 2009; Eaton, 2008). These services may be provided at in-home or in out-of-home settings to assist families in coping with the stresses of child care.

Family preservation services are short-term, family-focused, community-based services designed to help families cope with the stressors interfering with their ability to nurture their children. The goal of family preservation services is to maintain children within their families or to reunify them whenever this can be done safely. These services may be provided with or without assistance of Child Protective Services (CPS) and with or without a court order; however, families receiving these services are at risk for out-of-home placements for their children. Services include food stamps, substance abuse treatment, transportation, housing, welfare benefits, mental health treatment, and domestic violence treatment (Chambers & Potter, 2008).

Intensive family preservation services (IFPS), like family preservation services, are family-focused, community-based crisis intervention services designed to maintain children safely in the home and prevent unnecessary separation of families. IFPS are characterized by small caseloads for workers, short duration of services, 24-hour availability of staff, and the provision of services primarily in the family's home or in another environment familiar to the family, such as a relative's home. Services involve high levels of face-to-face contact with families, in-home service delivery, and linking families with community resources for reasons such as reducing social isolation, solving conflict between parents, assisting children with school-related difficulties, advocating for parents with legal problems, and education for parents on disciplinary issues (Hayward & Cameron, 2002).

Out-of-Home Care Alternatives

As described in previous chapters, if it is determined that a child is no longer safe from maltreatment within the home, that child will be placed in alternative care. Alternatives include emergency foster care, shared family care, kinship care, nonrelative foster care, therapeutic foster care, and residential group care. These placement alternatives must be either licensed by the state or approved by the courts.

Emergency care settings are temporary placements for children removed from their homes. These settings may be with another family or in a group facility. Children remain in emergency care to assure their safety while their needs

are assessed. Following the juvenile court hearing(s), the children are either reunited with their parents or moved to a more permanent placement.

Shared family care (SFC) provides placement for parent(s) and children to live together with a host family. This host family is trained to mentor and support the parents as they develop the skills and supports necessary to care for their children independently. SFC can be used to prevent out-of-home placement, to provide a safe environment for the reunification of a family that has been separated, or to help parents consider other permanency options, including relinquishment of parental rights.

Kinship care refers to the placement of children with relatives or, in some jurisdictions, close friends of the family. Kinship care is the preferred placement for children who must be removed from their homes because this kind of placement maintains the children's connections with their families. Kinship care can be formal and involve a training and licensure process for the caregivers, monthly payments to help defray the costs of caring for the children, and support services. Kinship care also can be informal and may involve only an assessment process to ensure the safety and suitability of the home along with supportive services for the children and caregivers.

Approximately one-fourth of American children in out-of-home care are living with relatives, and over 5 million (7.7% of all children in the United States) are living in homes with a grandparent as legal custodian (Wallace, 2001). As caregivers, grandparents incur a vast array of physical, emotional, and legal problems (Wallace, 2001). Whether these caregivers are eligible to receive assistance for themselves in their retirement years and, at the same time, for their grandchildren varies among states as to criteria for services. They need services such as child care, mental and physical health care, financial aid, authorization to act as substitute parents, housing, and legal representation (Okagbue-Reaves, 2005; Wallace, 2001). Policies are needed to provide the services to these grandparents, who need services for themselves as aging Americans and for their grandchildren as young citizens who are without the care of their natural parents (Okagbue-Reaves, 2005).

Children who cannot be placed with relatives enter **foster care**. This placement is in a family-type setting with nonrelative adults. Potential foster families must pass licensure requirements, including training, assessments, and recertification. "An estimated 45% of the 513,000 children in the U.S. foster care system are adolescents" (U.S. Department of Health and Human Services, as cited in Gramkowski et al., 2009, p. 77).

Ideally, children would remain in one foster home until they were reunited with their parents; however, children are often moved at least 4 times and as many as 20 or more times (Herrenkohl, Herrenkohl, & Egolf, 2003). Older children, especially adolescents, are more likely to change placements than younger children; girls are more likely to change placements than boys; and children with emotional or behavioral problems are more likely to experience a greater number of transitions (Herrenkohl et al., 2003). The more times they are moved, the more social and behavioral problems they may develop, such as dropping out of school, drug use, and mental health issues such as anxiety (Connell et al., 2006).

Children with special medical or behavioral needs may utilize **therapeutic foster care.** The adults within these families have received special train-

ing to care for children with the disabilities and also have fewer children in their care.

Residential group care refers to home-type facilities with specially-trained staff. Children living in residential group care usually exhibit physical or behavioral needs beyond the capabilities available in less restrictive settings (Ryan, Marshall, Herz, & Hernandez, 2008; Ward, 2006). These settings are also sometimes referred to as *congregate care* or *institutional care facilities.* Residential programs may be operated by public or private agencies and often provide an array of services including therapeutic, educational, and medical services. Of the more than half-million youth in out-of-home care, about 7% live in residential group care (Foster Care Statistics, 2009).

Long-term foster care (LTFC) is established for children who cannot be reunified with their families of origin. These children are prepared for independent living and receive training on financial matters and self-care. At age 18 years, they are emancipated and leave foster care.

Permanency Planning

When children are initially removed to an out-of-home alternative, the social worker collaborates with the parents/legal guardians in developing a permanency plan; ideally, if they are old enough to participate, the children should be involved in this plan. This plan establishes the goals and objectives as well as the time lines that parents are to follow to be eligible for reunification with their children (Tilbury & Osmond, 2006). The intent of permanency is to assure that the child has a stable living environment, strengthened emotional connections, and a sense of stability and identity.

Concurrent planning involves developing two plans simultaneously. One is to reunify the children with their parents. The alternative is to expeditiously find a more permanent placement for the children in the event that they cannot be reunified with their parents within a reasonable length of time.

If there is sufficient reason to exclude all possible legal, permanent family placements, the children enter Long-Term Foster Care (LTFC). Prior to this placement, Another Planned Permanent Living Arrangement (APPLA) case plan is written with them, which includes the children's developmental, educational, and other needs.

Children in Foster Care

Children below 4 years of age are twice as likely as older children to be placed in foster care (Craven & Lee, 2006). The most common reason for placement is neglect (Vig, Chinitz, & Shulman, 2005). Neglectful parents have a history of social problems, including substance abuse, mental health issues, intellectual delays, domestic violence, and social isolation; as a result, their children experience a disproportionate amount of medical, emotional, educational, and developmental problems (Craven & Lee, 2006). The children's developmental problems are exacerbated, once in placement, by lack of proper assessment and professional care, insufficiently trained foster parents, and numerous placement alternatives. In addition to the problems presented both by parents and the system,

children struggle with negative intrapersonal feelings (guilt and rejection) and interpersonal feedback such as ridicule from peers (Craven & Lee, 2006).

An estimated 82% of all the children in foster care have at least two chronic medical conditions as well as mental health and developmental problems (Vig et al., 2005). About 80% have been exposed to drug abuse, and 40% were born prematurely. Among the medical problems experienced by the younger children are failure to thrive, lead toxicity, and shaken baby syndrome (Vig et al., 2005).

A high percentage of these children have mental health conditions warranting intervention (Anderson, 2005; Craven & Lee, 2006). They manifest behaviors associated with PTSD, behavior disorders, anxieties, phobias, and depressive disorders. They may display behaviors such as fire setting, cruelty to animals, sexual acting out, aggression, hyperactivity, self-mutilation, lying, stealing, and eating disorders (McNeil, Herschell, Gurwitch, & Clemen-Mowrer, 2005; Pacific, Delaney, White, Cummings, & Nelson, 2005).

Many of these behavioral problems are associated with attachment issues. Being removed from their home at a young age can lead children to become unable to identify with a particular adult (or even a family); they have no one from whom they can draw strength and refuge. Their mental and physiological functioning cannot develop normally owing to past trauma and the inability to relate to a caregiver (Fish & Chapman, 2004).

Attachment theory, originated by Bowlby (1973), posits that a **secure attachment** is a basic requirement for healthy social and emotional functioning (Bacon & Richardson, 2001). Without the ability to attach to other people (i.e., to love and be loved), children lose their ability to cope with life stressors (Fish & Chapman, 2004). Healthy attachment is linked to resiliency and feelings of empathy, warmth, and the ability to form intimate, healthy interpersonal relationships throughout adulthood.

Children in foster care tend to demonstrate academic underachievement and often require placement in special education because of learning disabilities, language disorders, and adaptive behavior deficits (Evans, Scott, & Schulz, 2004). These children have higher rates of absenteeism, discipline referrals, and grade retention than their peers (Evans et al., 2004). As children move from one placement to another, they may switch schools, which also hinders their educational achievement (Evans et al., 2004; Zetlin, Weinberg, & Kimm, 2004).

Policies of Foster Care

The federal government has initiated numerous policies and programs for assisting maltreated children needing out-of-home placements. Despite this, the number of children in foster care keeps increasing, and the number of available foster homes keeps decreasing (Reifsteck, 2005). Emphasis for children in foster care tends to shift from reunification with their parents to permanency planning.

Some of the federal policies established for the protection of children in foster care are as follows (Reifsteck, 2005):

- *Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272)*: This act emphasized the creation of family preservation services such as counseling and parenting classes.

- *Adoption and Safe Families Act (ASFA) of 1997 (P.L. 105-89):* AFSA amended Title IV-E of the Social Security Act focusing on "reasonable efforts" to reunify children with their families. The policy emphasized permanency for children to ensure their safety, promoted adoptions, and provided safeguards allowing termination of parental rights (TPR) to be implemented more expeditiously.
- *Foster Care Independence Act of 1999 (P.L. 106-169):* This policy increased benefits for independent living programs, including Medicaid health insurance coverage for children under age 21, prevention-of-pregnancy programs, and substance abuse services. The act provided assistance for helping group-home workers, foster-care parents, and others involved with independent living and with preparing children for self-sufficiency. With its passage, the name of the Independent Living Program was changed; Long-Term Foster Care is the present terminology.
- *Keeping Children and Families Safe Act of 2003*: This amendment to the 1974 Child Abuse Prevention and Treatment Act (CAPTA) required "states to refer children younger than 3 who are involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA)" (Dicker & Gordon, 2006, p. 170). The Early Intervention Program (EIP) provides screenings for hearing, vision, and other physical signs of potential developmental delays in young children (Dicker & Gordon, 2006).

Foster Parent Programs and Professionals

Working with troubled children is challenging. Foster parenting requires an understanding of child development, behavior management, and psychology. Foster parents assume many roles: nurturer, mentor, protector, teacher, advocate, and team member. They interact with the children, biological parents, community agencies, child-care agencies, and society at large.

Social workers need special knowledge and skills to work effectively with foster children, foster parents, and biological parents. Children in foster care frequently require help in coping with their past abuse and the stresses of multiple placements. Foster parents need support and training. Biological parents deal with the stress of changing their present lives to make a safe environment for their children. Collaboration is needed among child welfare agencies, child development experts, and mental health therapists in developing strategies for handling the many stressors experienced by the parties involved in foster care.

Summary

This chapter covers the symptoms and consequences of child maltreatment and the various interventions available for families with a history of maltreatment. The consequences of child maltreatment can be categorized by the type of abuse, age of the victim at the time of intervention, and manifested behaviors. Symptoms interrupt the normal development of children neurobiologically, physically, emotionally, and cognitively; the consequences cost Americans billions of dollars every year.

For purposes of prevention, early intervention, and rehabilitation of problems within families, the child welfare system offers an array of services. In-home alternatives include family support, family preservation, and intensive family preservation services. Out-of-home alternatives include emergency care, shared family care, kinship care, family foster care, therapeutic foster care, and residential group care. When foster care is needed, the social worker collaborates with the parents in writing concurrent permanency plans: one for reunification and one for expeditious alternative care if reunification is not possible. Children in foster care experience transitions among placements, which further complicates their lives. The foster care system is complex and requires continued scrutiny and reform to better serve the children whose futures depend on homes in which they can feel safe, have a sense of belonging, and experience unconditional love.

Woman Gets 15 Years for Beating Her Son to Death

A woman whose 2-year-old son was beaten to death two years ago has been sentenced to 15 years in prison for his murder.

Lasha Roberts, 25, of the 2300 block of Montezuma Drive in Florissant, pleaded no contest on May 28 to charges of felony murder and child abuse before jurors—chosen the day before—could hear her case.

St. Louis County Circuit Court Judge Maura McShane imposed a 15-year sentence on Roberts for murder on Friday and a concurrent 15 years in prison for abusing her son, Jonathan Cooper, in September 2006. Under terms of the sentence, Roberts will have to serve at least 12¾ years in prison before she will be eligible for parole.

Roberts denied any wrongdoing in her plea but admitted a jury was likely to convict her if it heard the evidence. If she had gone to trial and been convicted, she could have gotten sentences up to life in prison on each count.

One of the scheduled prosecution witnesses was Dr. Raj Nanduri, a forensic pathologist who performed the autopsy on Jonathan. She found that the boy suffered contusions on his forehead, the left side of his face, his lungs and his adrenal glands. She determined the cause of death was blunt trauma to his head.

Nanjuri also had found evidence of prior injuries that had healed before he died, to his bowels, ribs and legs—and scars across his back indicative of beatings with a belt.

Police said Roberts told paramedics when they arrived at her apartment on Montezuma that Jonathan was comatose because he had fallen from a lower bunk bed.

At the hospital, Roberts told Florissant police Sgt. Michael Layton that she remembered her son had fallen from the top bunk the day before. Layton was the arresting officer.

(continued)

Prosecutor Gentry Smith said Roberts later admitted to Florissant detectives that she had shaken her son to stop him from crying, that she had whipped him with a belt and that she had shoved his head against a bedpost before putting him back in bed.

Before she called 911, Roberts waited 30 minutes—and made herself a sandwich, Smith said.

After her arrest, the Missouri Division of Family Services took two other children, a boy and a girl, away from Roberts after proceedings to strip her of her parental rights. The children are now living with relatives. (Lhotka, 2008)

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Discussion Questions

1. The mother, Mrs. Roberts, stated that her child fell from the top of the bunk bed. How believable is this explanation? What other evidence was present to make authorities doubt this explanation?
2. Two other children were in the home. Although not much was mentioned about them, what types of services would you anticipate they might need? What services might the relatives, who are providing kinship care, need?
3. What are the chances that these children will be resilient to these events in their lives?

Key Terms

Attachment theory
Child welfare system
Emergency care settings
Failure to thrive
Family centered services
Family preservation services
Family support services
Fetal alcohol effect
Fetal alcohol syndrome
Foster care
Intensive family preservation services
Intergenerational violence
Kinship care

Polyvictimization
Post-traumatic stress disorder (PTSD)
Residential group care
Resilience
Secure attachment
Shaken baby syndrome
Shared family care
Therapeutic foster care

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Assessment and Intervention in Child Maltreatment

6

Preschoolers Can Be Depressed, Too

We've heard so much about depression in adults and teens. But new research shows that even preschool-age children can experience early signs of depression.

Preschooler depression is much more than just being a quirky or shy child. Children as young as 3 years old show early, age-adjusted signs of clinical depression.

Some signs that your preschooler could be depressed include:

Does not seem to enjoy play.
Is often irritable or sad, whines or cries a lot.

(continued)

Avoids others.
Takes on excessive guilt.
Plays with an emphasis on sad–death themes.
Has had changes in appetite.
Seems tired and lacks energy.
Has minimal reaction to joyful events compared with peers.

While clinical depression is not common in preschool children, it is important that parents of preschoolers be tuned in to any abnormality or change in a child's behavior, especially among young children who come from families with a history of depression.

The best way to confirm whether your child exhibits clinical signs of depression is to consult a mental health professional. The sooner a toddler's depression is detected and diagnosed, the sooner the child can begin treatment and learn to manage depression into adolescence and adulthood.

While medication has become more widely accepted in treating adult depression, many parents I speak with are hesitant to consider medication for treating depressed children.

For preschoolers the first line of treatment would be a developmental–therapeutic one. I recommend that parents consider a therapy called parent–child interaction therapy–emotion development, which involves the child and parent or caregiver. It's medication-free and helps both the child and parent better understand ways to cope and become more emotionally competent in general. (Luby, 2009)

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Assessments and treatment modalities for maltreated children, as for any clients, are based on a solid theoretical framework. This chapter provides an overview of some potential approaches for working with abused children and their families. Readers are highly encouraged to familiarize themselves with overarching theories and their corresponding therapeutic approaches.

In addition to having a solid theoretical basis, assessment and treatment interventions must be grounded in the **evidence-based practice** model, which demands that empirical studies support a particular approach, given the same individual and environmental characteristics (Dufour & Chamberland, 2004). Individual characteristics might include the client's basic demographics and intellectual functioning. Environmental characteristics include location (e.g., rural or metropolitan) and availability of resources. This is not to say that research alone determines the therapeutic intervention to be used; rather, an evidence-based model integrates scientific evidence with the therapist's practice expertise and knowledge of the specific situation.

Evidence-based practice is part of the NASW Code of Ethics (National Association of Social Workers, 2008, Standard 5.02), which requires social workers to contribute to the evaluation of practice. Most research in human services takes place in real-life circumstances, without the benefit of ideal

experimental designs (James & Mennen, 2001). For example, the use of small, randomized samples and control groups is unrealistic in practice settings. However, although interventions are conducted with less-than-ideal research methodology, the results may provide useful data for future practice.

This chapter presents various assessment and therapeutic modalities for assisting maltreated children from infancy to adulthood.

Assessments of Maltreated Children

Social work assessments of maltreated children typically include biopsychosocial factors and operate from an ecological and systems perspective, which provides a holistic understanding of the problem and enables an evidence-based treatment modality to be implemented. Assessing maltreated children involved the entire family and their environment. Four areas of focus are risk, parent factors, child factors, and environmental factors (Lutzker, Van Hasselt, Bigelow, Greene, & Kessler, 1998).

When Child Protective Services (CPS) receives a report of child maltreatment, a two-phase assessment process begins. During phase I, CPS determines the existence of child maltreatment, gains insight into the persons involved, identifies underlying causes of the abuse, and makes recommendations for resolving the family's problems. During phase II, mental health professionals provide intensive assessments of the child, on the basis of which they implement the necessary intervention. (A more detailed discussion of these procedures is presented in Chapter 3.)

During the second phase, therapists use assessment tools and questionnaires to determine the various sources of trauma the child has sustained. It is important to remember that many of these children suffer from multiple traumas: first, from their maltreatment, and, second, from systems-induced issues, such as foster placement changes, court appearances, and a general lack of responsiveness to their needs.

Trauma produces a number of symptoms in children. One of the most common and immediate is **posttraumatic stress disorder** (PTSD) (Chaffin & Shultz, 2001), a mental disorder that follows extreme traumatic stress, with symptoms of

> *disorganized or agitated behaviors . . . reexperiencing of the traumatic event . . . persistent avoidance of stimuli associated with the trauma . . . increased arousal . . . lasting for more than 1 month, [and] . . . causing significant distress . . . in important areas of functioning. (American Psychiatric Association, 2000, p. 463)*

Accompanying these immediate symptoms are secondary symptoms including depression, self-destructive behaviors, anxiety, withdrawal, repressed anger, and low self-esteem. Some children have problems with social interactions (Blankemeyer, Culp, Hubbs-Tait, & Culp, 2002). Some children show aggressive behaviors, while others are unresponsive to friendly overtures from adults (Blankemeyer et al., 2002).

In assessing for the presence of these various types of symptoms, clinicians use instruments, observations, and interviews (Ammerman & Hersen, 1999).

Instruments are to be **psychometrically sound**, which means their *validity* (accuracy), **reliability** (ability to yield consistent results), and *cultural sensitivity* are established through empirically based theories and techniques (Berent et al., 2008; Monette, Sullivan, & DeJong, 2002). Specialized training is not required for many of these instruments. They are easy to obtain and are either free or low in cost. Instruments are to be selected depending on the characteristic that is to be measured (e.g., cognitive ability, anxiety, or depression), the child's age, and the suitability of the instrument for the child, including issues of gender and developmental level. Many resources for finding these instruments will explain the characteristic that the instrument is to measure, the time it would take to administer the instrument, its psychometric properties (validity and reliability), and the means for obtaining the instrument; however, these resources may not provide the actual instrument. Many instruments are copyrighted; therefore permission from the author must be obtained before they can be used. Sometimes authors will give permission to use their instruments at no cost. Other times, the instrument may be sold through a specific publisher. Once permission is granted, the instrument can be administered.

Listings of assessment instruments are readily available through *Buros Mental Measurement Yearbooks* (Buros, 2003). Fischer and Corcoran (2006) have published *Measures for Clinical Practice and Research: A Sourcebook,* which contains two volumes of instruments; one of which is dedicated to children and families. Professional texts, such as one edited by Stough, Saklofske, and Parker (2009) and one by Ammerman and Hersen (1999), contain instruments applicable to the children.

The following are some examples of instruments that can help in the assessment process:

- The Children's PTSD Inventory—a structured interview for assessing maltreatment among children and adolescents (Saigh et al., 2000).
- The Children Trauma Questionnaire (CTQ)—a five-factor model in the form of a brief self-report questionnaire for assessing childhood abuse among adolescents and adults (Scher, Stein, Asmundson, McCreary, & Forde, 2001).
- The Parent Report of Children's Experiences—assists adults in identifying maltreated children (Berent et al., 2008).
- The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983)—contains 118 items that are rated by the parent for children between 2 and 6 years of age to assess numerous areas, including "Schizoid/Anxious, Depressed, Uncommunicative, Obsessive-Compulsive, Somatic Complaints, Social Withdrawal, Ineffective, Aggressive, and Delinquent" (Gershater-Molko & Lutzker, 1999).
- Beck Depression Inventory (BDI; Beck & Steer, 1993)—measures depression in the parent using a 21-item scale.
- The Child Abuse Potential Inventory (CAP; Milner, 1986)—a six-factor scale measuring "Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, and Problems from Others."

Some instruments are *nonprojective* and others are *projective*. **Nonprojective instruments** require only objective interpretations of data. These instru-

ments typically utilize paper-and-pencil techniques, such as Likert-type scales and multiple-choice questions. Scoring may be as simple as tallying the correct responses.

Projective instruments require interpretation of unstructured stimuli. One example is play therapy, in which the therapist must interpret the meaning of the child's play activities. Projective instruments are more controversial in terms of their utility in detecting abuse (Garb, Wood, & Nezworski, 2000). Many projective techniques, such as the Rorschach, lack cultural sensitivity (Garb et al., 2000), while others, such as drawings, require a good deal of training to be interpreted properly (Garb et al., 2000). Some projective techniques, such as having children play with anatomically detailed dolls, may be intrusive (McGlinchey, Keenan, & Dillenburger, 2000). Both *nonprojective* and *projective* instruments can be useful during the assessment process provided that they are implemented with prudence.

In addition to using various instruments, therapists can use their observations of the child and his or her interactions with others. *Structured observations* are frequently performed during the assessment to ascertain the nature of the relationship between maltreated children and, most commonly, their nonoffending mothers (Tanner & Turney, 2000). During the observations the therapist observes the emotional engagement between the child and adult; however, no written notes are made at this time. Observations are intentional, focused, and nonparticipative. Following the session, a detailed account of the experience is written.

During the assessment process, observation is advisable within the school setting, where information can also be gathered from teachers. According to Garderer (as cited in Probst, 2006, p. 489), "there are seven distinct kinds of intelligence, [which] include: linguistic intelligence, logical–mathematical intelligence, spatial intelligence, musical intelligence, bodily–kinesthetic intelligence, intrapersonal intelligence (self-awareness), and interpersonal intelligence." Weakness in one or more areas will place additional stress on the child. By identifying these weaknesses, the therapist can build appropriate interventions in the treatment process with the child (Probst, 2006).

The results of these instruments and observations become part of the therapeutic assessment, which is, according to Finn (as cited in Glasser, 2007, p. 24), "a method of assessment in which assessors and clients work together to understand problems in living." This process is typically intended to last about 8 weeks, with one session a week (Tharinger et al., 2009). The first sessions enable the therapist to talk with the child's parent or guardian as to the results of the instruments and the therapist's observations. Information as to the child's symptoms is often gathered through indirect means, such as free and structured play (Tharinger et al., 2009). Several sessions are dedicated to gathering feedback from the parent(s), if available.

Assessments usually include a diagnosis according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2000); however, special care must be taken in working with children. Psychiatric diagnoses have been shown to be a risk marker for further victimization (Cuevas, Finkelhor, Ormrod, & Turner, 2009). Theoretical frameworks for working with maltreated children are conducted with the knowledge of abuse and neglect as "an experience, not a disorder" (Finkelhor & Berliner, 1995, p. 1415).

The distinction is more than semantic. If abuse is considered a disorder, children would be diagnosed and subsequently treated for their illnesses. Rather, when maltreatment is considered an experience, abused children are viewed as requiring time, patience, caring, empowerment, and the expertise of a trained professional to overcome their negative experiences (James & Mennen, 2001).

Upon completion of the assessment, the treatment plan is written by the clinician and clients (which would be the child's legal guardians), and the intervention is implemented; however, this process is not quite as simple as it appears on paper. Assessments are never-ending; they continue from the first meeting with the client to the closing of the case. Interventions, especially for abused children, must begin as soon as possible. In reality, the assessment, planning, and intervention steps are intertwined (Kirst-Ashman & Hull, 2009).

Interventions With Maltreated Children

Effective interventions require **cultural competence**, which calls for more than basic knowledge about other cultures. Instead, culturally competent practice requires an "informed not-knowing" approach, self-reflexivity, a multidimensional perspective of culture, and deconstruction of the term *culture* (Pakes & Roy-Chowdhury, 2007, p. 268). An "informed not-knowing" approach removes any feeling of being "all knowing" or "expert" and replaces it with an open, listening, and learning attitude. **Self-reflexivity** is the requirement for the practitioner to be aware of his or her own prejudices, biases, and stereotypes about cultural differences. A *multidimensional approach* to culture includes a plethora of characteristics about people, including but not limited to religion, language, occupation, and stage of **acculturation**—"a process that involves one culture trying to adapt to another, usually the dominant culture," according to Kim and Abreu (as cited in Hamid, Simmond, & Bowles, 2009, p. 69). Finally, a *deconstruction of culture* requires constant exchanging of ideas as to the meaning of words, actions, dress, and any means in which people communicate. The need for cultural competence is within the NASW Code of Ethics (National Association of Social Workers, 2008, Standard 1.05), which requires continual sensitivity to self and others.

Choosing the appropriate types of interventions for maltreated children requires additional empirical evidence that incorporates the child's age and the type of abuse (Ross & O'Carroll, 2004; Walrath, Ybarra, Sheehan, Holden, & Burns, 2006). A child's age at the time of onset (i.e., at the time the abuse began) influences the extent of the impact from the maltreatment (Kaplow & Widom, 2007). Children's age at the time of the intervention dictates certain abilities such as communication skills that can be used in the treatment strategies (James & Mennen, 2001; Kaplow & Widom, 2007; Ross & O'Carroll, 2004). At the risk of overly simplifying a complex issue, the following discussion organizes interventions by age and type of abuse.

Interventions by Age of Onset

For infants and very young children, interventions should address all members of the family (Rittner & Wodarski, 1995). Because abuse to very young children

is so deleterious to their well-being, both in the short and long term, all aspects of the family's lives need consideration. Strategies include parent effectiveness training, therapeutic day care, and, if necessary, residential care (Berry, Charlson, & Dawson, 2003; Dufour & Chamberland, 2004). In conjunction with these strategies, other types of interventions, such as cognitive behavioral therapies, may be used with the parents to help encourage positive behavioral change (Dufour & Chamberland, 2004).

Therapists can use **bibliotherapy** with children (Celano, Hazzard, Campbill, & Lang, 2002; Hahlweb, Heinrichs, Kuschel, & Feldmann, 2008). This type of therapy uses books to allow children to explore their emotions. Therapists encourage children to identify with the characters and events in the stories and thus help them think differently about their own situations (Celano et al., 2002).

Children as young as 3 years of age can experience cognitive, emotional, and behavioral problems rooted in their lack of socialization skills such as "turn taking" (Sinclair, Pettit, Harrist, Dodge, & Bates, 1994), assertiveness (Benenson, Aikins-Ford, & Apostoleris, 1998), and response to other children's aggression, according to DeRosier and colleagues (as cited in Blankemeyer et al., 2002, p. 209). Their inability to become socially competent at a young age tends to result in long-term negative consequences such as peer rejection, school maladjustment, and aggressive behaviors (Blankemeyer et al., 2002). Improvements for these children can be achieved by combining individual counseling and group involvement using strategies such as artwork, structured play, and role playing (Dufour & Chamberland, 2004; MacMillan, 2000). Children are grouped with age-appropriate peers; therefore the strategies utilized will depend on their developmental ages. These therapies have led children to exhibit less hypervigilance and aggression and more prosocial behaviors (Dufour & Chamberland, 2004).

Young children may respond well to music therapy, play therapy, and drama therapy (Lambert et al., 2007; Lefevre, 2004). Although her focus is music therapy, Lefevre explains the importance of these various types of symbolic approaches for both assessment and therapeutically focused work with children. Communication with children must relate "to features such as the child's age, gender, culture, language, developmental stage and any disability" (p. 334). Children may not have the language to name their experience nor the intellectual and affective frameworks to process them. They can, however, express themselves and find their voice through symbolism, play, and creativity.

Music therapy originated in the 1950s as a means to help people heal and originally, was popular in hospital settings before moving into the therapeutic arena (Lefevre, 2004). Music therapy can enhance communication, self-expression, and personal growth (Lefevre, 2004). Children become actively involved in the therapeutic process through means such as playing a musical instrument, singing (thus expressing themselves), and writing songs. Through music, children can access unbearable emotions and communicate with the therapist about their experiences and pain (Lefevre, 2004).

Play therapy has been shown to be helpful for children who suffer a multitude of problems including those suffering from posttraumatic stress disorder (PTSD; Ogawa, 2004). Play therapy's theoretical orientation is primarily child-centered, cognitive behavioral, and Adlerian (Lambert et al., 2007). The various

modalities that are used include sand play, art therapy, activity therapy, family therapy, and movement play (Lambert et al., 2007). Play therapy offers children a safe place where the incidents that they suffered are reframed. Their feelings are validated; their anger is refocused; and they receive affirmation of self. Play therapists offer their clients empathy, warmth, and acceptance. Play therapy has been successful with children of varying ethnicities (Jones, 2002). Social workers and others who are trained in play therapy may be members of the Association for Play Therapy (APT) and/or the American Counseling Association (ACA). Most are employed in private practice and mental health settings (Lambert et al., 2007).

Drama therapy, along with music and play therapies, is a type of symbolic play used by therapists to help maltreated children. For younger children, drama therapy takes the form of puppet and magic shows (Dufour & Chamberland, 2004). When children reach about 9 years of age, and are abused, they start engaging in thoughts about getting revenge on their perpetrator, and this desire for retribution is common (Haen & Weber, 2009). Acting out these fantasies enables them to choose a more "effective sublimation of the wish for revenge than is offered in the verbal therapy arena" (Haen & Weber, 2009, p. 88).

As children mature into adolescents, various types of writing and talking therapies are helpful for working through the traumatic events in their lives. "Self-disclosure [through diary writing] has been demonstrated to be a key contributing factor for emotional writing to show therapeutic effect," says Pennebaker (p. 39). Diary writing is also referred to as *journaling, narrative writing,* and *expressive writing* (Romero, 2008). Writing letters to the offender, even if they are not mailed, has been shown to be helpful in facilitating the expression of feelings and promoting forgiveness, which can prove to be the catharsis of the trauma (Celano et al., 2002; James & Mennen, 2001; Romero, 2008; Ross & O'Carroll, 2004). Through **catharsis,** individuals "express strong emotions while mentally re-living . . . an early traumatic experience. Based on Freud and Breuer's case observations, this discharge or purging of strong affect was thought to result in reduction of neurotic symptoms" (Kaminer, 2006, p. 484).

Preadolescent and adolescent girls, particularly those who are sexually abused, respond positively to group therapy (Staller & Nelson-Gardell, 2005). The group enables them to self-disclose and discuss the abuse with others who shared similar experiences (Staller & Nelson-Gardell, 2005). Group therapy can relieve feelings of isolation, increase self-reliance, gain trust, and create an understanding of the abuse as experienced by others (Staller & Nelson-Gardell, 2005). Other benefits are better impulse control and increased self-confidence (Thun, Sims, Adams, & Webb, 2002). Many of the symptoms of abuse do not surface until these girls reach puberty; thus they experience a renewed trauma that requires additional help and attention (Thun et al., 2002).

Interventions by Type of Maltreatment

Many interventions address children's needs by the age of onset of the abuse and age at time of intervention; however, certain interventions are presented by the type of abuse children have suffered. Chapter 2 lists and defines four types of abuse: sexual abuse, physical abuse, emotional abuse, and neglect. The types of abuse are addressed here in the same order.

Sexual abuse often leaves its victims with feelings of shame and guilt (Cohen & Mannarino, 2002). Shame is characterized by dejection, humiliation, and a desire to hide; whereas guilt is a feeling of responsibility for what happened. Therapists may tell abused children they are not responsible (i.e., not guilty) of the abuse, yet these children remain shame-based (i.e., feeling as if they were bad people) because of the abuse. Shame-based children are unable to distinguish between feeling ashamed, which means internalizing negative thoughts about the behaviors committed against them, as compared with feeling shame, which means internalizing feelings that they are bad people because of the abuse.

A means for empowering victims of sexual abuse is to develop an *emergency escape plan* (Cohen & Mannarino, 2002). Children need to feel that they have some control over their lives. Having a plan of action gives them control, so that they can "escape" whenever they perceive danger. Their escape plans can include going to a neighbor or calling the police. The escape plan gives children power over the situation and enables them to feel comfortable with people designated as being "safe."

Group interventions have proven effective with sexually abused youth. Techniques may include role playing and art therapy (Dufour & Chamberland, 2004). Positive results are reported for these youth, including decreased fear, anxiety, and depression and increased self-esteem, feelings of competence, and concept of self (Dufour & Chamberland, 2004).

Physically abused children can suffer long-term consequences, as described in Chapter 5; however, when children are physically abused, treatment has tended to focus on the parents rather than the children (James & Mennen, 2001). Although the parents need professional intervention, the children, also, require therapeutic intervention. Treatment can focus on children's aggression, social and interpersonal competence, and developmental deficits. Further empirical information is needed as to effective techniques with physically abused children (James & Mennen, 2001).

Emotional and psychological maltreatment can result in learning and behavioral problems in those who are abused (James & Mennen, 2001). Obtaining help for children who are victims of these types of abuse is difficult because the actions against them are typically not detected, reported, or successfully prosecuted (James & Mennen, 2001). Emotionally abused children often reach adulthood before they can address the consequences of the maltreatment.

Neglect is the most common type of maltreatment, yet it remains the most understudied (Berry et al., 2003; James & Mennen, 2001). Young children who are neglected suffer serious developmental problems that may last into adulthood. Intervention must focus on the entire family and provide physical, mental health, educational, and similar services to reverse the child's developmental setbacks (Berry et al., 2003). Social support and concrete case management with the parents have proven more successful than traditional psychotherapy services (Berry et al., 2003). Services to parents use a social learning and behavioral approach to model appropriate child-rearing behaviors. Other services can help parents address unemployment, substance abuse, psychiatric problems, and other "material needs, emotional and other stresses, and social skills and relationships" (Berry et al., 2003, p. 22).

Additional Interventions With Maltreated Children

Despite the information that is available about various treatment modalities, findings as to their effectiveness remain sparse and continued evaluations are needed (Becker-Weidman, 2006). Further specialized strategies that have been used to help children recover from the trauma of maltreatment are discussed in the following sections.

Animal-Assisted Therapy

As a consequence of their abuse, children develop emotional problems, experience trauma, suffer insecure attachment, and live with a myriad of health problems. **Animal-assisted therapy** (AAT) and animal-assisted activities (AAA) provide avenues for overcoming these difficulties (Parish-Plass, 2008). These types of therapies can reduce heart rate, lower blood pressure, relieve anxiety, and show other physiological benefits that add to the favorable outcomes of the recovery process (Jalongo, Astorino, & Bomboy, 2004).

AAT is "a goal-directed intervention that utilizes the human-animal bond as an integral part of the treatment process" (Kogan, Granger, Fitchett, Helmer, & Young, 1999, p. 106). AAT is part of a longer-term treatment plan or curriculum (Jalongo et al., 2004), whereas AAA involves short-term encounters. Both AAT and AAA therapists must be certified and insured. Many programs operate in collaboration with various organizations such as schools, mental health organizations, and hospitals.

Various types of animals are used for AAT and AAA; the most common are dogs and horses (Ewing, MacDonald, Taylor, & Bowers, 2007). Therapy dogs, as well as cats and other small animals, can help children by diverting their attention to the animal. Children will read to and share stories with dogs, which they will not tell to adults, and they find the dogs to be good listeners and confidantes (Jalongo et al., 2004). As children care for and ride horses, they develop social skills such as trusting, improving their focus, understanding boundaries, and relieving loneliness.

Common objections to these modalities include concerns about sanitation, safety, allergies, cultural differences, and fear of animals (Jalongo et al., 2004). However, these issues can be addressed. Overall, these programs have shown positive results. Kogan et al. (1999) reported on the use of AAT with two troubled youth. By participating in the AAT program, both children achieved most of their goals, feeling a sense of pride and accomplishment and improving their self-esteem and interactions with others. Other researchers have reported positive results using animals to help children overcome the adversities of maltreatment (Parish-Plass, 2008; Reichert, 1998).

Dyadic Developmental Therapy

Based on Bowen's attachment theory, **dyadic developmental therapy** is a form of intervention for maltreated youth 5 to 17 years of age and is intended to relieve numerous symptoms including withdrawn behaviors, anxiety, depression, social problems, thought problems, and aggression (Becker-Weidman, 2006). Like other social work interventions, dyadic developmental psychotherapy

gives "attention to dignity of the client, respect for the client's experiences, and starting where the client is" (Becker-Weidman, 2006, p. 150). This approach differs from traditional psychotherapy by placing greater emphasis on the close relationship between the therapist and the child. Together they reexperience the traumatic event while the therapist uses some specific techniques such as eye contact, cognitive restructuring, and nurturing. As in other specific types of therapeutic interventions, the proper implementation of dyadic developmental psychotherapy requires specialized training for child therapists.

Cognitive Behavioral Therapy

For both individual and group therapeutic settings, **cognitive behavioral therapy** (CBT) is an effective means to decrease the psychological symptoms associated with the trauma of child maltreatment (Cohen, Mannarino, Berliner, & Deblinger, 2000). CBT has an exposure component, including **imaginal flooding,** which can decrease PTSD in abused children through an ongoing contact with stimuli that produce fear or anxiety. During clinical interviews anxiety-provoking scenes are discussed and children imagine the details of the scene. Through gradual exposure, children describe aspects of the trauma beginning from less to more intensely upsetting. Repeated exposure can help children experience the abuse with reduced negative emotions.

Cognitive interventions comprise another component of CBT (Cohen et al., 2000). The therapist asks the maltreated child to describe his or her thoughts about what happened during the abuse and try to give meaning to what occurred. Often, children will identify feelings of self-blame, survivor guilt, and negative views of self. The therapist corrects cognitive errors (as when the child blames himself or herself for the abuse or wonders if she or he could have prevented maltreatment), identifies current cognitions, evaluates reasons for cognitions, and corrects them. Through this process, children learn to challenge originally negative thoughts and replace them with more positive alternative thoughts.

Components of CBT can be used with all members of the family; CBT has been used by children as young as 3 years of age (Cohen & Mannarino, 1996). Parents can focus on their beliefs, attitudes, perceptions, and expectations about their children. Abusive parents often expect more than their children are developmentally able to do (Deblinger, Stauffer, & Steer, 2001); thus they believe that their children are purposely misbehaving when in fact the children may only be acting in a developmentally appropriate manner. Parents are taught how to better understand the developmental processes of their children and to appreciate their children's achievements. Nonoffending parents are an integral part of this recovery process and can act as mediators between the child and the abusive parent (Deblinger et al., 2001). In time, parents and children can receive joint sessions, enabling them to communicate in a safe environment and to work toward healthy interactions at home.

Eye-Movement Desensitization and Reprocessing (EMDR)

According to Shapiro (as cited in Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004, p. 359), **eye-movement desensitization and reprocessing** (EMDR) is "a treatment for traumatic memories and their sequelae that requires the client

to perform bilateral eye movements while concentrating on the trauma memory treatment components . . . including psycho-education, coping skills training, and exposure." The treatment procedure can be adjusted for the child's age and developmental level (Ahmad & Sundelin-Wahlsten, 2008). The session begins with a relaxation technique and the child is asked to describe "the contents of a chosen enjoyed memory in details. This is considered as *safe place*" (Ahmad & Sundelin-Wahlsten, 2008, p. 129). Throughout each treatment session, this *safe place* remains an important component. Children as able to explore and differentiate positive from negative thoughts and feelings. Children are to attend at least eight sessions of 45 minutes each (Ahmad & Sundelin-Wahlsten, 2008). EMDR has been found to be successful in helping children reduce the posttraumatic stress symptoms and improve their behaviors (Jaberghaderi et al., 2004).

Licensed clinical social workers can specialize in child therapy, which is a challenging field, especially with children who communicate using nonverbal interactions and play. Understanding children and helping them to view the world as a place of opportunity rather than a place of pain challenges the best of social workers, yet the intrinsic rewards are priceless.

Adult Survivors of Childhood Maltreatment

In 1985, Finkelhor, Hotaling, Lewis, and Smith (1990) conducted a seminal study on adult survivors of childhood sexual abuse. The participants (1,145 men and 1,481 women) were asked four questions about their childhood. A history of childhood sexual abuse was revealed by 27% of the women and 16% of the men. One of the principal findings from the study was the high number of adults who had suffered child abuse.

Annually, thousands of adults seek professional help for physical, psychological, and emotional problems resulting from abuse and neglect when they were children (Finkelhor et al., 1990). Presumably many more fail to seek help. Adults who are seeking help are typically called "survivors" or "thrivers" (Palmer, Brown, Rae-Grant, & Loughlin, 2001).

Symptomology

Adult survivors of child maltreatment often have distorted cognitive and emotional orientations toward the world (DiLillo, Giuffre, Tremblay, & Peterson, 2001). They think something is wrong with them because they were maltreated; they view the world as cruel and believe that the use of force is the only way to raise children. This distortion leaves them with a poor self-concept, which in turn results in self-defeating behaviors and, at the extreme, suicidal ideation (Brayden, Deitrich-MacLean, Dietrich, Sherrod, & Altemeier, 1995; Thakkar, Gutierrez, Kuczen, & McCanne, 2000).

Depression, which commonly accompanies poor self-concept, manifests itself in nonspecific associated symptoms such as eating disorders and addictions (Zuravin & Fontanella, 1999). For example, an estimated one-fourth of American women who engage in bulimia were sexually abused (Wonderlich & Wilsnack, 1996). Women survivors of sexual abuse commonly become addicted to alcohol or illegal drugs (Thakkar et al., 2000).

PTSD is a common occurrence to survivors, during which they relive the abuse through dreams, nightmares, and flashbacks. They may experience various physical reactions, withdrawal, or emotional outbursts (Rodriguez, Ryan, Rowan, & Foy, 1996). Numerous survivors report somatic problems resulting from their childhood abuse (Thakkar & McCanne, 2000), including gynecological problems, reproductive problems, digestive problems, headaches, and asthma.

Adult survivors experience problems with interpersonal relationships, including the formation and continuation of intimate relationships (Whiffen, Thompson, & Aube, 2000). In contemplation of parenting, they set boundaries and reenact deprivations they experienced as children (Salzberg, 2000). If they do become parents, they may tend to be punitive, cold, and controlling (Trute, Dockling, & Hiebert-Murphy, 2001) or, at the other extreme, may be overly permissive (Ruscio, 2001).

Assessment

Careful and thorough assessment is needed to determine the severity of the various conditions interfering with adult survivors' well-being. A spiritual–biopsychosocial view provides a strong foundation on the basis of which the survivor and social worker can proceed. Listening to the clients' stories and validating their experiences is vital for enhancing their self-esteem and family functioning. Throughout the interactions, empathy, acceptance, and a nonjudgmental attitude strengthens the client (Palmer et al., 2001).

In providing information about their past, including the abusive experiences, clients expose themselves to the threat of being revictimized through reliving the childhood trauma. To reduce the risk of potential distress and enable clients to review their answers, an increasing number of therapists are conducting their assessments using computers (DiLillo, DeGue, Kras, Di Loreto-Colgan, & Nash, 2006). Computers give clients more control over the extent of the interaction during any one session, thus reducing the stress. The disadvantage of computer-based assessments is their inability to provide feedback and support to the interviewee. Nevertheless, computers are serving a valuable role in the assessment process (DiLillo et al., 2006).

Psychometrically designed instruments are available for gathering data during the assessment. Considering the range of potential conditions experienced by these clients, **rapid-assessment instruments** (RAIs) are particularly useful for obtaining data from them. These are paper-and-pencil tests that take little time, perhaps 5 to 10 minutes, to determine the extent to which adults are experiencing the impact of abuse. Instruments are available for gathering information on any of the client's symptoms, such as the Adult Sexual Experience Questionnaire (ASEQ; Thakkar et al., 2000) or the Extended Personal Attributes Questionnaire (EPAQ; Whiffen et al., 2000).

Various resources are available for locating instruments that would be of assistance in the assessment process (mentioned earlier in this chapter; see the section on Assessments of Maltreated Children). Several instruments for adults include:

- The Multi-Attitude Suicide Tendency Scale (MAST)—"is a self report measure designed to assess four conflicting attitudes related to life and death" (Thakkar et al., 2000, p. 1349) designed by Orbach et al. (1991).

- The Early Trauma Inventory (ETI)—measures general traumatic experiences, physical violence, emotional violence, and sexual abuse (Śpila, Makara, Kozak, & Urbańska, 2008) designed by Bremner's team at Emory University School of Medicine (Bremner, Vermetten, & Mazure 2000).
- The State–Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983)—"assesses anxiety related to any specific issue of concern" (Edmond, Rubin, & Wambach, 1999).
- The Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979)—assesses posttraumatic stress symptoms for any specific trauma.
- The Beck Depression Inventory (BDI; Beck & Steer, 1993)—measures symptoms of depression including irritability, hopelessness, and fatigue.
- The Belief Inventory (BI; Jehu, Gazan, & Klassen, 1985)—identifies and measures common distorted beliefs among adult survivors of childhood sexual abuse.

The assessment process should also evaluate sources of **resiliency** in adult survivors of childhood abuse. Resilient adults tend to engage in four types of cognitive strategies: disclosing and discussing, minimizing, positive reframing, and refusing to dwell on the maltreatment (Himelein & McElrath, 1996). They have discussed their experiences with friends and family and remain willing to talk about their experiences. They tend to minimize the abuse and deny the maltreatment as the greatest stressor in their lives. Instead, they view the experience as a means for personal change or growth. This optimism acts as a defense mechanism, which protects them from hopelessness. They think about the past but refuse to dwell on it.

Professional help can transport adults who suffer from past abuse, from lives filled with destructive behaviors to a state of hope and optimism. Cognitively confronting and reflecting on the past experience can help reframe and work through it (Himelain & McElrath, 1996). Treatment interventions vary in type and length depending upon the individual, environment, and relevant therapeutic conditions.

Interventions With Adult Survivors

The majority of studies on interventions with adult survivors tend to focus on female survivors of childhood sexual abuse (Foynes, Freyd, & DePrince, 2009). More research is needed on male victims and on victims of other forms of childhood abuse. Nevertheless, sufficient information is available to provide some guidelines for initiating therapy with adult survivors of child abuse.

Adult survivors commonly experience depression, anger, and sadness (Palmer, Brown, Rae-Grant, & Loughlin, 1999). They may not have disclosed their abuse, instead keeping their victimization a secret (Palmer et al., 1999). They may have developed addictions (Cohen et al., 2000). Their memories of maltreatment may be inconsistent (Foynes et al., 2009). They have problems with the discipline of their children (Ruscio, 2001; Trute et al., 2001). Adult survivors are at high risk for revictimization, meaning that they tend to suffer additional abuse from others because of their vulnerabilities (DiLillo et al., 2001). Adult victims of child abuse bring a vast array of intra- and interpersonal problems into the therapeutic setting.

Disclosure (telling other people) of the abuse is a major part of the recovery process. Adult victims may not have disclosed the abuse as children for fear of the negative consequences to them and others. These fears included the perpetrator harming other family members; feelings of self-blame and confusion; lacking awareness of the pressure for secrecy; unconsciously using defense mechanisms such as cognitive dissonance and denial; and thinking no one would believe them and that they deserved the abuse (Palmer et al., 1999).

Disclosure changes secretiveness to openness, shame to self-satisfaction, confusion to understanding, and numbness to expression. With disclosure, survivors of child abuse can receive professional help in resolving their internal conflicts (Palmer et al., 1999).

Adult survivors need the therapist to listen to them and to believe them (Gasker, 1999). They need someone to validate their experiences. The therapist can help clients to tell their life stories and reframe their negative perceptions, such as self-blame. This listening, believing, and reframing are vital parts of empowerment.

As clients reframe their cognitive processes, attitudes, and feelings about the past, they move to a healthier state of being (Palmer et al., 1999). They reexamine their present situation and plan for the future. As they become "thrivers," they move on from the negative experiences of the past, learn to love themselves, and live for the present and future (Palmer et al., 1999).

Adult survivors can benefit from group therapy, it enables survivors to hear other people's stories and realize they are not alone with their experiences and feelings (Himelein & McElrath, 1996; Palmer et al., 1999). They share their thoughts and feelings with others, who understand what they have experienced. Family and friends can also play important roles (Gasker, 1999). They need to listen to survivors and let them know they are believed.

Couples therapy may be used during the treatment process. This approach has proven effective for women who have been sexually abused (Trute et al., 2001). Such women often have problems in their intimate relationships. They may experience sexual problems relating to desire, excitement, and orgasm (Sarwer & Durlak, 1996). As adults, these women can recover only by dealing with their anger, coping with stressors in their lives, and examining their attitudes toward their intimate partners. Engaging a couple in therapy can help them to improve their communication and resolve their relationship problems.

Another effective therapeutic technique, principally used for clients suffering PTSD, is EMDR, which was discussed above (Edmond et al., 1999). This treatment, also known as reprocessing therapy, was developed by Shapiro (1989). During it, the therapist waves a stick or light in front of the patient. The patient watches the stick or light while concentrating on his or her problems (Edmond et al., 1999). The phases of EMDR involve gathering information, preparing the client, assessing, desensitizing through eye movement, installing positive cognition, scanning the body for residual material, closure, and reevaluation (Edmond & Rubin, 2004, p. 70). The movement is intended to send signals to the brain that unblock the information processing system and enable patients to work through their difficulties.

Edmond et al. (1999) randomly assigned 59 adult female survivors of childhood sexual abuse to one of three groups. One group received EMDR; the other

two received either routine individual treatment or no treatment. (The "no treatment" control group received treatment later.) Edmond et al. (1999) found statistical and clinical significance to support the effectiveness of EMDR, although the findings seemed tempered by lack of significant difference between EMDR and individual therapy.

Lau and Kristensen (2007) used systemic and analytic group psychotherapy to alleviate symptoms of PTSD with 74 adult female survivors of childhood sexual abuse. The women were randomly assigned to one of the two groups. Analytic group psychotherapy emphasizes the group process rather than the therapist; whereas systemic group psychotherapy "integrates social constructionist philosophy with methodology from solution-focused therapy, including a narrative approach" (Lau & Kristensen, 2007, p. 97). Statistically significant results were reported for systemic group psychotherapy in helping survivors of childhood sexual abuse.

Other approaches have shown evidence of helping adult survivors of child abuse. Briere (1989) provides "survivor-oriented therapy" based on a psychodynamic philosophy for working with survivors of childhood sexual abuse. Strategies include transference and countertransference, role playing, desensitization, relaxation, and *inner child* work. Anderson and Hiersteiner (2008) report the benefits of self-narrative in group treatment settings in recovering from childhood sexual abuse as clients proceed through disclosing the trauma, making sense of it, and building supportive relationships. It seems that more empirical evidence of successful therapeutic approaches for adult survivors of childhood abuse is needed, especially considering the apparent concentration on child abuse and the scarcity of reports on other types of abuse.

A basic principle of the social work profession is to treat each person with respect of his or her inherent dignity and worth. Clients cannot be categorized as having had a particular experience and thus reacting in a certain manner. Social workers cannot predetermine the outcome of their assessments or the type of therapeutic treatment to implement. At the same time, knowledge of empirical evidence as to past correlates of abusive experiences and resulting consequences, as well as the competent assessment tools and therapeutic techniques, is expected of every social worker counseling clients. This chapter provides a discussion of these correlates and evidence-based intervention models and thus offers a basis for additional work in this area.

Summary

Assessment with abused children and their families is a two-phase process consisting of determining the validity of the abuse and planning for the intervention. Both immediate and secondary symptoms need assessment, especially in very young children. Evidence-based practices, with accompanied psychometrically sound instruments, help assure the effectiveness of the assessment and intervention processes.

Therapeutic involvement with children can be individual, group, or family, depending upon the child's age at the time of onset of the abuse, age at the

time of intervention, and type of abuse. Children must be at least 3 years of age to engage in group therapy. Once they are adolescents, they respond most effectively to the group setting. Children who are sexually abused can begin their empowerment through techniques that overcome their shame and guilt. Neglected children require a family-type approach with special attention to their delayed developmental issues.

Multiple treatment modalities are available for helping maltreated children regardless of the type of abuse. Play therapy, animal-assisted therapy, cognitive behavioral therapy, and dyadic developmental therapy are some interventions that may be used; each requires specialized training for the social worker implementing them with children.

Numerous assessment tools are available for adult survivors of child maltreatment and in determining the level of their symptoms. Throughout their recovery, survivors experience, among other emotions, anger and depression. Clients' resiliency is an individual characteristic that should also be explored and encouraged.

As social workers conduct assessments and interventions, they are to be culturally competent and to demonstrate empathy, warmth, and genuineness. They should also listen, believe, and give time to their clients as they disclose their experiences of the maltreatment, thus enabling them to heal.

Ruling Spurs Repressed-Memory Debate

The ruling the Missouri Supreme Court has OK'd a suit based on repressed memories, such as those David Clohessy . . . of SNAP says he has.

TROUBLE AHEAD? Some health professionals are skeptical of such memories and say vulnerable people could become prey for the unscrupulous.

David Clohessy was watching a movie when he says the first memory came back to him—a horrible image that he says remained deep in his subconscious for more than 20 years. The memory was of sexual abuse at the hands of a priest. Clohessy was 12.

"If you had asked me before that movie if I had been abused, I would have said no," Clohessy said. "And I would have passed a lie detector test, too. That's how repressed those memories were."

In 1991, Clohessy filed a lawsuit against the priest. Because of the Missouri statute of limitations, the case was thrown out a few years later. But last week, the Missouri Supreme Court broke with precedent and allowed a man to proceed with a lawsuit based on repressed memories. The ruling may have opened the door for scores of similar cases, such as Clohessy's. Advocates called it a victory for victims of abuse.

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Many health professionals see only trouble ahead—for the courts and for people wrestling with inner demons. "I think this was the wrong decision," said Steven Bruce, director of the University of Missouri at St. Louis' Center for Trauma Recovery. "It could well open the floodgates for these kinds of cases, and I'm not so sure that will be a good thing for many of these people."

Are memories real?

According to Bruce, mental health professionals are divided over the issue of repressed memories. Many respected professionals doubt their existence or, at the very least, their accuracy.

UMSL's trauma center specializes in treating the adult survivors of abuse. Bruce, who said he believed cases of true repression were very rare, said he was afraid that the recent ruling could open the door for the unscrupulous to prey upon the vulnerable. "Suggestion is a powerful force, especially for someone wrestling with a lot of issues," he said.

The idea of repressed memories is a relatively new psychological theory. In 1990, in a landmark case from California, George Franklin, 51, was convicted of a 20-year-old murder based mainly on the testimony of his daughter, Eileen. The victim was an 8-year-old friend of Eileen's named Susan Kay Nason. Eileen testified that her father had killed Susan. Eileen said she had repressed the memory for almost 20 years.

Over the years, such cases have become more commonplace. However, the debate continues unabated. Barbara Dorris, outreach director for the Survivors Network of those Abused by Priests (SNAP), said that in general, younger victims experienced repressed memory—a "survival mechanism" that allows them to cope with the abuse. "The kid becomes two kids; the kid who was abused, and then there's this other kid who comes down and eats cornflakes and goes to school," she said.

Clohessy, SNAP's national director, can relate. He said it made perfect sense for a small child to bury painful memories. "How else can a child's mind deal with something so horrible?" he said.

But according to Donna LaVoie, a psychology professor at St. Louis University and an expert on memory, such memories are often faulty. "Our memories are not like videos," she said. "We don't simply play back what happens to us exactly like it happened. In every memory, there is a little fact, a little fiction and a little perception."

La Voie said this was especially true of so-called recovered memories. She said that although there was sometimes a kernel of truth there, it was polluted by other influences. "We are able to produce phantom recollections in people," she said. "We can actually make people believe they remember something that never happened. So this can be dangerous ground."

The current Supreme Court case deals with sexual abuse that is alleged to have happened 30 years ago at Chaminade College Preparatory School. Michael Powel filed suit in 2002 naming Chaminade, the Marianist religious order that operates it, former Archbishop Justin Rigali and two faculty members—a priest and a religious brother—accusing the

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teachers of molesting him in the mid-1970s, when he was 15 to 17 years old.

Decision's Effect

Lawyers who are still in the process of examining the Supreme Court's opinion say the full meaning and effect of the decision will depend on how it is interpreted in upcoming court cases and appeals.

"I have nothing but questions myself," said Gerard Noce, who is representing Chaminade and the Marianists in the Powel case. Noce said he was very skeptical of repressed memory. But Patrick Noaker, a lawyer from Minnesota who has filed more than 2,000 clergy or school sex abuse cases nationwide, said only a "loud minority" remained skeptical.

Perhaps the loudest critic of repressed memories is Elizabeth Loftus, a psychology professor with the University of California at Irvine. She is coauthor of "Witness for the Defense: The Accused, the Eyewitness and the Expert Who Puts Memory on Trial." Loftus is considered one of the leading national experts on the issue of repressed memories. She calls them the "mental health scandal of the 21st century." "There is no credible scientific evidence to prove that repressed memories even exist," she said. "And yet they keep clearing the way for these kinds of trials which have ruined hundreds, if not thousands, of families."

The skeptics upset Clohessy. He agrees with Noaker that it is a loud minority of mental health professionals who don't believe in repressed memories. "It is very painful to me to have anyone, especially in the mental health community, doubt the existence of repressed memories," he said. "I know dozens, if not hundreds, of people who have experienced them. We all cope with trauma in different ways." (Barbour & Patrick, 2006)

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Discussion Questions

1. What are your opinions as to the validity of repressed memories in survivors of childhood abuse? On what basis do you make your opinions?
2. On what grounds, if any, do you think children have a right to sue their parents over damages stemming from childhood abuse? What other types of provisions can be made to resolve these issues between adults and their parents?
3. What are differences between adult children suing their parents, other family members (e.g., an uncle or brother), and nonfamily members (e.g., neighbors or clergy) on the issue of past child abuse?

Key Terms

Acculturation
Animal-assisted therapy
Bibliotherapy
Catharsis
Cognitive behavioral therapy
Cultural competence
Drama therapy
Dyadic developmental therapy
Evidence-based practice
Eye-movement desensitization and reprocessing (EMDR)
Imaginal flooding
Music therapy
Nonprojective instruments
Play therapy
Posttraumatic stress disorder (PTSD)
Projective instruments
Psychometrically sound instruments
Rapid-assessment instruments
Reliability
Resiliency
Self-reflexivity

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Introduction to Intimate Partner Violence

7

Domestic Violence Happens to Others and Then, Perhaps, to You

The first thing experts will tell you about the typical victim of domestic violence is that there is no such person. Other than the victims being overwhelmingly female—more than 90 percent of domestic violence is committed by men against women—they can be anyone.

College graduates and high school dropouts, married and single, young and old, working and unemployed. These women live next door to you in big cities or small towns, upscale homes or trailers. They work in stores, and they work in offices. They're everywhere.

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No woman thinks it will happen to her. It happens to someone else. Someone who lives in another town, someone who didn't finish school, someone who doesn't have a good job.

I never thought it would happen to me. But it happens somewhere in the United States between 1 million and 4 million times a year. Somebody has to make up those statistics.

My story isn't all that rare. My (now ex-) husband and I were having serious problems. No kidding, right?

He came home late, with liquor on his breath. I was in bed, sleeping, until I heard the garage door creaking up its track. Who said what no longer matters. What matters is that he hit me. Hard enough to make my nose bleed. Hard enough to make my ears ring. Hard enough to turn my left ear black with bruises.

I didn't call 911 when it happened. The arrival of the police would wake up the whole neighborhood. One of my children was home; the other was spending the night with a relative. No children should see their mother bruised or bleeding at the hands of their father.

He left for work later that morning. I left my children with relatives and went to the police. Walking into that station was harder than it should have been. I started to hedge.

The officer was polite. He asked simple questions. And then, bless the policy of St. Clair County, it was out of my hands. The officer told me that police were required to arrest a person suspected of committing domestic violence. Even if the victim didn't want the suspect arrested.

No hemming, no hawing, no mulling it over.

My ex was arrested and charged with domestic battery, a misdemeanor. I went to court and got an order of protection, which ordered him to vacate our home and keep his distance from me. He pleaded not guilty to the criminal charge. Five months later, we went to court.

The trial bore no resemblance to what we see on television. No majestic courtroom, no bombshell testimony, no surprise confession. I told my version of what happened that August night. He told his. As you might expect, the stories were wildly different.

In his version of events, he claimed he never hit me. Not once. Instead, he said, I hit him. When he grabbed my arm to stop me, my fist ricocheted back and I hit myself. That's how I got the bloody nose, the swollen eye, the blackened ear.

The attorney representing the people of St. Clair County gave a brief closing argument. My ex-husband's attorney did the same.

Judge Alexis Otis-Lewis ruled immediately. She convicted him of domestic battery and sentenced him. He got a fine, a year of probation and mandatory counseling. With that, it was over. He was a wife-beater. I was a battered woman.

Compared with many women, I was lucky. It happened only one time. Some women endure frequent abuse. Fear or shame or ignorance stop them from getting the help that's out there. Luckily, I had enough educa-

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tion and support from friends and family to get through a terrible time. Some women don't.

Even now, years after it happened, the memory of that night rekindles my sorrow and my shock that it could happen to me.

October is National Domestic Violence Awareness month. Be aware. It can happen to you, or to your friend, or to your neighbor. Someone has to be part of those numbers. (St. Amand, 2006)

—Reprinted from the October 8, 2006, issue of the *St. Louis Post-Dispatch* (MO).

This chapter provides a foundation for understanding intimate partner violence. IPV is also commonly referred to as *domestic violence, spouse abuse, wife battering,* or *family violence.* In efforts to prosecute perpetrators and protect victims, many public policies and legislative actions have been passed, the most expansive being the **Violence Against Women Act** of 1994. Despite these efforts, IPV is experienced by 1 in 4 women in the United States (Tjaden & Thoennes, 2000). Underlying theories, a historical perspective, predictors, policies, and prevalence reports are presented in this chapter.

IPV Defined

The Centers for Disease Control and Prevention define intimate partner violence (IPV) as "abuse that occurs between two people in a close relationship. The term *intimate partner* includes current and former spouses and dating partners. IPV exists on a continuum from a single episode of violence to ongoing battering" (Centers for Disease Control and Prevention, 2006, p. 2). Laws define which individuals can be arrested for committing these acts of violence; however, IPV may occur in a manner that, although not illegal, is devastating to victims' well-being. In essence, "domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners" (Healey, Smith, & O'Sullivan, 1998, p. 3). These behaviors are devised and carried out precisely to enforce the perpetrator's power over his or her partner (Healey et al., 1998).

Other terms are used to describe various types of IPV (Johnson & Leone, 2005). **Intimate terrorism** refers to physical and sexual assaults. Violence resistance is violence that is used in response to intimate terrorism; these acts are similar to self-defense. **Situational couple violence** occurs as a result of periodic serial conflicts.

Prominent Theoretical Perspectives on IPV

The **radical feminist sociocultural theory** is commonly used to provide a theoretical explanation for IPV (Damant et al., 2008). This theory attributes the

occurrence of IPV to a patriarchal social structure, meaning a system wherein children and women have less power than men. Less power makes them susceptible to abusive acts (Damant et al., 2008). By virtue of inevitably viewing males as perpetrators and females as victims, the theory is considered to be gender asymmetrical (Damant et al., 2008; Goldner, 1999; Hamel, 2009). This theory serves as an argument to shift the social power structure based on gender, to treat intimate violence as a criminal act, to punish within the criminal justice system, and to position mental health professionals on the side of the victims (Goldner, 1999).

Postmodern feminist theory shuns a "males versus females" approach; instead, it emphasizes differences among, as opposed to between, men and women (Damant et al., 2008). It recognizes the importance of motherhood in women's lives and focuses on the complex connections between domestic violence, child abuse, and mothering (Damant et al., 2008). Postmodern feminism emphasizes power differentials between and among individuals, thus dispelling an all-or-nothing perspective (Damant et al., 2008). "An important issue with postmodern feminism is that it tends toward individualism and relativism and rarely provides the basis for collective political actions" (Damant et al., 2008, p. 126).

Over time, alternative theoretical perspectives to the feminist theory evolved predicated on the belief that no one single paradigm could provide an explanation for intimate violence and that a multitude of factors other than power account for couples staying together despite intimate violence between them (Goldner, 1999). The singular focus on power and inequality has the effect of shaming women who choose to remain in these relationships, making them vulnerable to victim-blaming explanations such as *low self-esteem, dependency,* and *masochism* (Goldner, 1999, p. 326).

Multiple perspectives have replaced the monolithic radical feminist view of IPV and have pushed responsibility for explaining and treating families that experience IPV further into the realm of mental health and social services (Goldner, 1999). **Intersectional feminism** (Bograd, 1999; Damant et al., 2008) proposes that IPV is only one form of oppression and social control and that life occurs within an "intersection of systems of power (e.g., race, class, gender, and sexual orientation) and oppression (prejudice, class stratification, gender inequality, and heterosexist bias)" (Bograd, 1999, p. 276). Just as the occurrence of IPV cannot be explained simply by a single demographic difference, so too therapeutic approaches need to expand to address the complexity of the issue. Race and ethnicity, social class, sexual orientation, societal forces, cultural differences—life and relationships consist of multiple forces, and all intersect (play a part) and affect families. Solving the crises of IPV is the responsibility of all individuals within various professions who "already have power and prestige to shoulder the responsibility of expanding our models, examining our practices, and giving voice to those who are silenced among us" (Bograd, 1999, p. 285).

Object relations theory addresses intrapsychic processes that influence interpersonal behavior (Zosky, 1999). "Humans are motivated from earliest moments by the need for significant relationships with objects" (Fairbairn, 1952, and Summers, 1994, as cited in Zosky, 1999, p. 57). People must be able to develop trust and security in self and the object world. Children look to their parents to be the objects of love and security. When their sense of security is undermined, as by witnessing IPV, children can no longer maintain a sense of

self-esteem and lose the ability to regulate their emotions. As they mature, they look elsewhere (to other objects of affection) to fulfill their needs, as to another adult, and to recover the sense of security they did not have as children (Zosky, 1999). When they choose a partner, they become enmeshed with him or her. Perpetrators become violent when their wishes are unmet and panic-stricken at the thought of being abandoned; thus they strike out in violence and then become remorseful—thus demonstrating the three phases of IPV (see Chapter 8) (Zosky, 1999).

Gender-Inclusive IPV

Some researchers and clinicians propose that IPV is gender symmetrical, meaning that women and men participate equally in the violence between them (Johnson & Leone, 2005). This theory suggests that violence can be mutual and can be female-perpetrated. "Research has proliferated within the typologies/asymmetry framework . . . and the time [seems] right for another alternative to the gender-feminist patriarchal model" (Hamel, 2009, p. 44). **Gender-inclusive theories** of IPV assumes that IPV can be mutual and systemic in nature. This concept addresses all types of violence—not just physical—and proposes that women initiate IPV as often as men do, especially in the realm of verbal and emotional abuse. The concept calls attention to the children in families and the negative consequences they suffer from witnessing IPV, regardless of who starts it (Hamel, 2009). The causes of violence are complex and evolve from personal and cultural issues, both past and present. Because both men and women can come from violent home backgrounds, both are responsible for intergenerational violence, which passes aggressiveness on from one generation to the next (Hamel, 2009).

Whether IPV is *gender symmetrical* or *asymmetrical* determines the polices that are established and the treatment that is provided (Hamel, 2009). Most existing policies and treatments focus on punishing male batterers and supporting female victims. If, however, IPV is considered to be symmetrical, where both men and women can be perpetrators and/or victims, then gender bias should be eliminated from policies and services. Ideally, treatment would be more flexible and would include "intensive individual therapy, structured couples counseling, mixed-gender perpetrator groups, family therapy, and restorative justice approaches" (Hamel, 2009, p. 45).

IPV and Same-Sex Couples

The theories presented above address IPV between heterosexual couples. Various theories have also been posed as to the underlying causes of violence between same-gender partners. Island and Letellier (1991) attributed IPV between same-gender partners to personality characteristics. Renzetti (1996) asserted that societal pressures forced same-gender couples to remain silent about abusive relationships, partly because of internalized homophobia (feelings of guilt) and partly because of externalized homophobia (societal discrimination).

Combining various theories, Merrill (1996) posited that violence between same-gender partners could be explained by sociopsychological theory, in particular in terms of three aspects: perpetrators learn to abuse from their families

of origin; they have the opportunity to abuse when their partners choose to remain silent; and they eventually choose to abuse. While agreeing with Merrill's model as applicable to gay male violence, an exception is made in explaining violence between lesbian partners (McClennen, 1999). Lesbians continue to experience sexism, which places women in a subordinate position to men. Additionally, lesbian partners tend to become more enmeshed in their relationships based on their socialization and because they live in a homophobic society (Miller, Greene, Causby, White, & Lockhard, 2001). For these reasons, lesbian partners are a more vulnerable population than gay male partners. Thus the patriarchal sociopsychological theory can explain the underlying causation and continuation of lesbian partner violence.

Brief History of IPV Laws and Policies

Table 7.1 offers a brief history of prominent American attitudes, policies, and laws toward IPV. Prior to the 19th century, men were allowed to beat and even kill their wives without receiving admonishment (Schornstein, 1997). In 1768, common law asserted that a husband could beat his wife as long as the stick was no thicker than his thumb; thus, the phrase "rule of thumb" (Dutton, 2006, p. 7) The church supported the right of men to be the heads of their households and the obligation of women to be submissive to their husbands (Dutton, 2006). According to the civil law of interspousal immunity, married women did not have legal identity separate from their husbands and could not sue their husbands for any reason, including assault or rape (Walker, 2002).

In 1848, women at the Seneca Falls Convention in New York State discussed their social, religious, and civil rights and began advocating for equality and freedom from abuse within their own homes (Hogan, 2008). However, it was not until 1920, with the passing of the 19th Amendment, that women won the right to vote.

In the 1970s—more than 100 years after the Seneca Falls Convention—feminist advocates were able to gain sufficient momentum to have abused women acknowledged and assisted by a larger segment of society. Publications such as Pizzey's *Scream Quietly or the Neighbors Will Hear* (1974) and, later, Martin's *Battered Wives* (1981) and Walker's *The Battered Woman Syndrome* (1984) drew attention to the pervasiveness of violence against women.

In America, the women's movement against domestic violence had its origins in the movement against rape (Walker, 2002). In 1966, the National Organization for Women (NOW) was formed to represent women (Walker, 2002). "Take Back the Night" marches claimed women's right to walk on streets without being assaulted and raped. With the leadership of Erin Pizzey, battered women's shelters were established in England, setting the model that America would adopt (Walker, 2002). "The first shelters for abused women and the rape crisis lines were established in the early 1970s" (Bala, 2008, p. 273). "In 1977, a historic conference on women was held in Houston, Texas, in conjunction with the UN Decade of Women . . . [and] stopping violence against women, especially battered women, rose to the top of the agenda" (Walker, 2002, pp. 87–88).

In 1978, representatives from battered women's shelters met at the invitation of the U.S. Health and Human Services Agency (USHHS). In 1979, the

7.1 Milestones of the Women's Movement and Attitudes and Policies Toward Intimate Partner Violence

Time Period	Women's Movement	Intimate Partner Violence
Colonialism to early 1800s		■ Domestic violence considered a private affair ■ Supreme Court upheld "Rule of Thumb"
Mid to late 1800s	■ Seneca Falls Convention (1848)	
1920s	■ Women win the right to vote (1920)	
1930s	■ Welfare for single mothers established through provisions in the Social Security Act of 1935	
1940s		■ The United Nations Economic and Social Council (ECOSOC) establishes the Commission on Status of Women (1946)
1960s	■ *Feminine Mystique* by Betty Friedan is published (1963) ■ National Organization for Women (NOW) is established (1966) ■ Birth control pill introduced to the public (early 1960s)	■ Wife abuse research begins ■ "Stitch Rule"
1970s	■ Equal Rights Amendment passed (1970) ■ *Roe* v. *Wade* decision (1973) ■ NOW Task Force on Rape established (1973)	■ First shelters for abused women established (early 1970s) ■ First hotline for battered women established (1972) ■ NOW task force on battered women established (1976) ■ National Conference on Battered Women held ■ U.S. Commission on Civil Rights holds a forum entitled Consultation on Battered Women in Washington, D.C. (1978) ■ *Scream Quietly or the Neighbors Will Hear* by Erin Pizzey is published (1974)

(continued)

7.1 (continued)

Time Period	Women's Movement	Intimate Partner Violence
1970s (cont'd)		■ *Battered Wives* by Del Martin is published (1976) ■ National Coalition Against Domestic Violence established (1978)
1980s		■ The first national "day of unity" to commemorate victims of violence is established by the National Coalition Against Domestic Violence (1980) ■ The National Coalition Against Domestic Violence holds the first national conference in Washington, D.C. (1980) ■ Family Violence Prevention & Services Act passed (1984) ■ *Thurman* v. *Torrington* lawsuit (1985); leads to Connecticut's first mandatory arrest law ■ "No-drop" policies established ■ October recognized as Domestic Violence Awareness Month (1987) ■ U.S. surgeon general identifies domestic violence as major societal problem (1988)
1990s and beyond	■ Personal Responsibility and Work Opportunity Reconciliation Act passed (1996); includes Family Violence Amendment	■ The Centers for Disease Control establish the Family Violence and Intimate Violence Prevention Team (1993) ■ O. J. Simpson trial (1994) ■ Violence Against Women Act passed (1994)

National Coalition Against Domestic Violence was formed. In 1984, the U.S. Domestic Violence Prevention Act was passed, and by the mid-1990s the Office on Women was reestablished within the Department of Justice (the first office having been opened in 1980 but closed due to lack of funding; Walker, 2002).

In the mid-1970s, police practices in incidents of violence were criticized from numerous fronts (Sherman & Berk, 1984). Battered women wanted an in-

crease in arrests. "Surveys of battered women who tried to have their domestic assailants arrested report that arrest occurred in 10 percent [Roy, 1977, p. 35] or 3 percent [see Langley & Levy, 1977, p. 219] of the cases . . . Police responding to disputes in . . . Boston, Washington, and Chicago . . . made arrests in 26 percent of the cases" (Sherman & Berk, 1984, p. 262). Psychologists, however, argued that police should rarely make arrests, thus enabling therapeutic action for the perpetrator. Feminists sought more arrests for the safety and dignity of women (Sherman & Berk, 1984). Police officers were reticent to respond to domestic disputes, considering them as nuisances, but also considering them dangerous and often resulting in injury and death (Pagelow, 1997).

In 1981 and 1982, The Minneapolis Domestic Violence Experiment (MDVE) was funded by the National Institute for Justice to determine the effectiveness of mandatory arrests by law enforcement in cases of partner violence (Sherman & Berk, 1984). Patrol officers who participated in the study were given three potential responses to domestic violence reports when they visited the homes: (a) separate the individuals; (b) attempt to provide advice and mediation; or (c) make a **mandatory arrest**, which means taking the abuser into legal custody. Based on the lower rate of recidivism, mandatory arrest policies were recommended. Despite later studies reporting varying results (Berk & Newton, 1985; Dunford, Huizinga, & Elliott, 1990), the MDVE became a landmark study demonstrating the need for changes in police policies in cases of partner violence (Cho & Wilke, 2005).

In the early 1980s, the need for reform was further emphasized by two lawsuits that drew national attention. In the cases of *Sorichetti* v. *City of New York* (n.d) and *Thurman* v. *City of Torrington* (n.d.), the abused women had obtained orders of protection and divorce papers, and they had requested police protection numerous times. Yet in both cases their pleas were minimized; the police made no arrests and the victims sustained permanent physical damage. In both these cases, the victims sued their respective city governments on the grounds that their civil rights were denied when city officials (i.e., police) failed to protect them. Both victims were awarded appreciable monetary compensation for their suffering (Walsh, 1995).

In 1994, the federal government passed Title IV of the Violent Crime Control and Law Enforcement Act (P.L. 103-322), commonly known as the Violence Against Women Act (VAWA). This legislation had four parts: (a) Services, Training, Officers, Prosecutors (STOP) Violence Against Women grant programs; (b) Safe Homes for Women; (c) Civil Rights for Women & Equal Justice for Women in the Courts; and (d) Protections for Battered Immigrant Women and Children (Cho & Wilke, 2005). Through it, grants were awarded for increased training, technical assistance, shelters, prevention, coordination, mandatory arrests, prosecution, and protection for victims. "The positive effects of the VAWA demonstrated in [their] study should be seen as evidence that efforts to address domestic violence have had some success, though much work remains" (Cho & Wilke, 2005, p. 138).

Types of IPV

Policies addressing IPV commonly categorizes these acts of abuse into four types: (a) physical, (b) sexual, (c) psychological, and (d) economic (Tjaden &

Thoennes, 2000). Stalking is also often added as a separate category, and is an act of increasing prevalence (Morrison, 2008). The following provides some specifics as to acts committed.

Physical Abuse

Physical abuse is the easiest to observe and most commonly associated with domestic violence (Straus & Gelles, 1986; Tjaden & Thoennes, 2000; Weisz & Tolman, 2000). Examples of violence against partners include victims being:

- Scratched
- Pushed or shoved
- Struck or threatened with objects
- Punched, hit, struck with fists
- Kicked
- Cut by carving into the skin
- Burned with cigarettes or other objects
- Pushed down stairs
- Choked or suffocated
- Threatened with a gun
- Shot or stabbed
- Verbally threatened with violence
- Driven recklessly (in a car) to scare
- Interrupted in sleeping or eating
- Spit upon
- Restrained
- Left with destroying property
- Forced to watch or know of abuse of their children
- Forced to watch or know of abuse of their animals

Sexual Abuse

Examples of sexual abuses against a partner (Campbell, 1999; Marshall, 1992) include victims being:

- Forced to have sex
- Denied protection against sexually transmitted diseases
- Penetrated with objects against their will
- Forced to have oral sex

Psychological Abuse

Psychological (emotional) abuse is the least understood (Sims, 2008) and is often discounted by victims as not being abuse. Perpetrators may label their comments as "kidding," thus, leading their victims to believe they are overly sensitive and without a sense of humor. Victims may describe unsettling situations but don't recognize their abusive nature; they know only that the acts cause them emotional pain. Psychological abuse is not only the least understood by the public but also the least researched (Montminy, 2005; Seff, Beaulaurier, &

Newman, 2008). Other examples (McNamara & Brooker, 2000; Montminy, 2005; Tjaden & Thoennes, 2000) of psychological abuse of a partner include victims being

- Made fun of for their appearance
- Verbally demeaned in front of others
- Isolated from friends, family, and other individuals
- Blamed for the abuse
- Accused of flirting or cheating unfairly

Economic Abuse

With financial or economic abuse, perpetrators may try to keep their victims from becoming independent and thus no longer needing the perpetrator. Examples of economic abuse (Weaver, Sanders, Campbell, & Schnabel, 2009) against a partner include victims being

- Prevented from getting or keeping a job
- Forced to ask for money
- Left with a ruined credit rating
- Forced to support the perpetrator

Stalking

"About 5 percent of [8,000] surveyed women and 0.6 percent of [8,000] surveyed men reported being stalked" (Tjaden & Thoennes, 2000, p. iii). **Stalking** is essentially a repeated act of intimidation. Examples of stalking (Morrison, 2008) include

- Being followed or spied on
- Having the perpetrator stand outside the victim's home, school, or workplace
- Receiving unsolicited phone calls
- Having the perpetrator show up at the same places where the victim is even though the perpetrator has no business being there
- Being given unwanted items
- Being communicated with in other ways against one's will
- Having property or something one loves be vandalized or destroyed

Prevalence and Incidence of IPV

Prevalence refers to the percentage of persons within a demographic group who experience partner violence during a specific time period. **Incidence** refers to the number of separate incidents of violence committed against persons during a specific period (Tjaden & Thoennes, 2000). Incidence rates tend to be higher than prevalence rates since one person may experience more than one type of abuse (i.e., physical and sexual) or a particular type of abuse more than one time (i.e., being physically abused multiple times).

It is especially difficult to collect valid data on IPV, as compared with data on crimes committed by strangers, and to interpreting the trends partly because of the varying definitions of *family,* the changing family structure; and methodological problems (Straus & Gelles, 1986; Tjaden & Thoennes, 2000).

The first major barrier to valid data collection is the definition of *family*. Some research studies on IPV report data only on married couples; others include cohabitating couples and/or dating couples. Some studies include data only on heterosexual couples; others include data on opposite-gender and same-gender couples; and some combine the data regardless of gender orientation.

The second major barrier to accurate data collection and interpretation is the changing American family structure. The proportion of two-parent households is declining; however, the number of unmarried-couple and single-parent households has been increasing over the past three decades (Straus & Gelles, 1986; Kenney & McLanahan, 2006).

Some studies report that cohabiting couples experience a higher rate of intimate-partner violence than married couples for reasons such as the presence of marital norms (Ellis, 1989) and the weaker norms of sexual exclusion (Brownridge & Halli, 2002; Wilson & Daly, 2001). Kenney and McLanahan (2006) question the findings of these reports based on the heterogeneity of the two groups.

A third major barrier involves overcoming methodological problems, such as victims' reticence in discussing personal matters, the private nature of these acts, and the perceived stigma associated with being a victim (Bachman & Saltzman, 1995). Methodological factors also include different designs, samples, and survey administrations (Bachman, 1998). Further research is needed to determine "how methodological factors such as sample design, survey administration, survey introduction, and question wording affect research findings on IPV" (Tjaden & Thoennes, 2000, p. 20).

National Family Violence Surveys

The National Family Violence Surveys, conducted in 1975 (Straus, Gelles, & Steinmetz, 1980) and 1985 (Straus & Gelles, 1986), are two classic studies of family violence—both child abuse and IPV. Both used representative samples of 54 million couples (Wolfner & Gelles, 1993). Data were collected on violence between married or cohabiting persons ages 18 and over using the Conflict Tactics Scale (CTS). The CTS measures the use of violent acts (threw something at the other; pushed, grabbed, or shoved; slapped or spanked; kicked, bit, or hit with a fist; hit or tried to hit with something; beat up the other; threatened with knife or gun; and used a knife or gun; Straus & Gelles, 1986, p. 467).

In both studies, *abuse* was defined as physical (resulting in pain and injury [Straus & Gelles, 1986, p. 467]).

In these studies, *overall violence* indicated the percentage of participants who were victims of any type of violent act collected by the CTS. *Severe violence* was defined as acts having the probability of causing an injury. (In referring to severely violent acts, the term *wife beating* was used; Straus & Gelles, 1986, p. 468).

The second study found the number of women beaten by their intimate partners was approximately 1.6 million—a number that, as the authors stated, "is hardly an indicator of domestic tranquility" (Straus & Gelles, 1986, p. 470).

Between the first and second studies, "overall violence" declined 6.6% and "severe violence" declined 26.6%. Straus and Gelles (1986) provided several potential explanations for the differences. For one, a change in research methodology: In 1975, the data were collected via in-person interviews; in 1985, the surveys were conducted over the telephone. The researchers predicted that because telephone surveys allow respondents a measure of anonymity, callers were expected to be more willing to discuss personal issues such as IPV; thus the second study should reveal higher rates. Instead, the rate decreased. The authors suggested that perhaps "it more likely that the violence rate is higher among those who refuse to participate" (Straus & Gelles, 1986, p. 472). Second, they speculated that respondents may have been more reluctant to admit to partner violence in 1985 because of society's increased awareness and disapproval of it. Third, an increase in victims' services may have led to a decreased number of partners remaining in violent relationships.

A controversial issue in both surveys was **gender symmetry**, the concept that men and women can be equally prone to use violence against each other (Straus & Gelles, 1986). For "overall violence," the rate per 1,000 couples in 1985 was 113 husband-to-wife as compared with 121 wife-to-husband. The authors conjectured that women used violence in retaliation or in self-defense and, because of differences in physical size, men were more likely to hurt the women they hit, as opposed to the situation when women hit men (Straus & Gelles, 1986, p. 470). The contention over gender symmetry continues both within theoretical literature (Damant et al., 2008; Goldner, 1999; Hamel, 2009) and the prevalence literature (Bachman & Saltzman, 1995; Tjaden & Thoennes, 2000).

National Crime Victimization Survey

The Bureau of Justice Statistics (BJS) has sponsored the National Crime Victimization Survey since 1972 (Bachman & Saltzman, 1995). In this survey *violence* is defined by actual or attempted rape, robbery, assault, larceny, burglary, and motor vehicle theft; acts of family violence are included in this survey (Bachman, 1998). In 1993, the victimization survey (Bachman & Saltzman, 1995) form was revised to more accurately estimate incidents of rape and violence perpetrated by intimate partners (Bachman, 1998). That year, the nationally representative sample consisted of approximately 50,000 housing units and 101,000 persons. The victimization survey was administered using face-to-face interviews conducted by individuals from the U.S. Bureau of the Census. Participants included individuals 12 years of age or older. The relationship between victims and perpetrators is broad—anywhere from strangers to parents or spouses (Bachman, 1998).

Bachman (1998) compared the rates of domestic violence reported in the National Family Violence Survey, conducted in 1985 by Straus and Gelles (1986), with the rates reported in the National Crime Victimization Survey conducted in 1993 (Bachman & Saltzman, 1995). One of the noted differences between the surveys was gender symmetry (i.e., whether or not the rate of violence is the same from female to male as compared with male to female). The Family Violence Survey (Straus & Gelles, 1986) reported the existence of gender symmetry. The 1986 survey reported 116 per 1,000 husband-to-wife violence (or 11% of the couples with male as perpetrator) and 124 per 1,000 wife-to-husband violence (or 12% per couple with female as perpetrator; Bachman, 1998, p. 2). The data from

the Victimization Survey (Bachman & Saltzman, 1995) refuted this finding and reported, in heterosexual relationships, 9.3 per 1,000 male-to-female violence (male perpetrator) and 1.4 per 1,000 female-to-male violence (female perpetrator). The victimization survey (Bachman & Saltzman) clearly showed that women were victims more often than males, thus supporting gender asymmetry (Bachman, 1998).

As to the issue to gender symmetry, Bachman (1998) attributes the differences in findings between the Family Violence Survey (Straus & Gelles, 1986) and the victimization survey (Bachman & Saltzman, 1995) to methodological issues such as sampling, number of times the participants were interviewed, context of the survey, number of household members interviewed, and context of violence. The Family Violence Survey (Straus & Gelles, 1986) collected data with the presentation of *conflict resolution;* however, the National Crime Victimization Survey (Bachman & Saltzman, 1995) collected data as *crimes* (Bachman, 1998, p. 5). The Family Violence Survey collected data from a stricter sampling (e.g., husband and wife or cohabiting couple) as compared with the victimization survey, which collected information from all members of the household over 12 years of age. "Research demonstrates that estimates using the CTS [which is the Conflict Tactics Scale used for collecting data by Straus and Gelles in 1986] methodology will usually find gender symmetry . . . because the context of the violence is not taken into account; however, this symmetry is somewhat erroneous" (Bachman, 1998, p. 6).

National Violence Against Women Survey

The National Violence Against Women (NVAW) survey was conducted from November 1995 to May 1996 (Tjaden & Thoennes, 2000) and sponsored by the National Institute of Justice and the Centers for Disease Control. A nationally representative sample of 8,000 women and 8,000 men, age 18 and over, was selected randomly (Tjaden & Thoennes, 2000). Data were gathered by telephone interviewers using a structured survey form that included violent acts such as rape, physical assault, and stalking perpetrated by current and former dates, spouses, and cohabiting partners (Tjaden & Thoennes, 2000).

The findings from the NVAW (Tjaden & Thoennes, 2000) support the findings from the Victimization Survey (Bachman & Saltzman, 1995) as to gender symmetry. The survey's findings were that "women are significantly more likely than men to report being victimized by an intimate partner" (Tjaden & Thoennes, 2000, p. 17). Therefore both the NVAW (Tjaden & Thoennes) and the Victimization Survey (Bachman & Saltzman, 1995) suggest that men perpetrate violence against women more often than women perpetrate violence against men.

The NVWA survey addressed the comparison among the three national surveys and their differences in estimates (Tjaden & Thoennes, 2000). Conclusions as to the differences among the Family Violence Survey (Straus & Gelles, 1986), the Victimization survey (Bachman & Saltzman, 1995), and the NVAW survey (Tjaden & Thoennes, 2000) are attributed to the different research methodologies including sampling and instrumentation (Tjaden & Thoennes, 2000).

The contention as to gender symmetry remains and requires continued attention. The question as to whether women and men are equally prone to violence toward their intimate partners influences policies, programs, treatment

modalities, and services. The criminal justice system is influenced by the answer (Hamel, 2009; Straus & Gelles, 1986). If police are called to a domestic dispute and they believe both partners are equally violent, then both partners could be arrested (Hamel, 2009). Court cases involving the self-defense of women against their assailants have already resulted in prosecution of the women on the basis that the battered woman syndrome does not exist (Straus & Gelles, 1986). Funding for shelters, prevention, and treatment of female victims only is challenged on the basis of gender symmetry (Hamel, 2009; Straus & Gelles, 1986). Treatment for perpetrators would have to change to address both genders (Hamel, 2009). Understanding and responding to IPV is dependent on "enlightened awareness" as to the validity of research findings, and more findings are needed to bring the truth to light (Bachman, 1998, p. 7).

The *Extent, Nature, and Consequences of Intimate Partner Violence* (the subject matter of the NVAW survey) reported various findings (Tjaden & Thoennes, 2000), some of which are as follows:

- Annually, approximately 4.5 million male intimate physical assaults are perpetrated against U.S. women (p. 10).
- Annually, approximately 2.9 million female intimate partner physical assaults are committed against U.S. men (p. 10).
- Annually, in the United States, 503,485 women and 185,496 men are stalked by an intimate partner (p. 10).
- Violence perpetrated against women by intimates is often accompanied by emotionally abusive and controlling behavior (p. iv).
- Men living with male intimate partners experience more IPV (15%) than do men who live with female intimate partners (7.7%; p. iv);
- Women living with female intimate partners experience less IPV (11%) than women living with male intimate partners (30.4%; p. iv).
- Rates of domestic violence vary among women of diverse racial backgrounds; however, differences diminish when other sociodemographic and relationship variables are controlled (p. iv).
- Most intimate partner victimizations are not reported to the police. Approximately one-fifth of all rapes, one-quarter of all physical assaults, and one-half of all stalkings perpetrated against female respondents by intimate partners were reported to the police (p. v).

Prevalence Among At-Risk Populations

The National Violence Against Women (NVAW) survey reported on the occurrence of violence among minority populations. Approximately 28.6% of non-White women, as compared with 24.8% of White women, are victimized by an intimate partner in the course of their lives (Tjaden & Thoennes, 2000). For men the victimization rate is 10% non-White men compared with 7.5% White men. These figures are limited to acts of rape, physical assault, and stalking (Tjaden & Thoennes, 2000).

In the NVAW survey, both American Indian/Alaska Native women and men report a higher rate of victimization by an intimate partner in their lifetime than White, African American, Asian Pacific Islander, or other Mixed Race women and men (Tjaden & Thoennes, 2000). Both Asian Pacific Islander women and men

report the lowest rate of domestic violence among all ethnic populations (Tjaden & Thoennes, 2000). Partner violence in at-risk populations is discussed in more detail in chapter 13.

Adolescent Dating Violence

Approximately one in three high school students experience some form of dating violence (Gray & Foshee, 1997). **Dating violence** includes physical, sexual, and psychological abuse as well as stalking and can be conceptualized as "a constellation of several abusive and violent behaviors" (Theriot, 2008, p. 224). Prevalence rates vary depending upon a range of factors including conceptualization of types of aggression, sample characteristics (age and socioeconomic variation), and other methodological issues. Some research suggests that an estimated 40% to 80% of adolescents experience some form of dating violence (Hickman, Jaycox, & Aronoff, 2004).

Some researchers have found that adolescent couples report *mutually violent* dating relationships (those in which boys and girls use violence against one another). Gray and Foshee (1997) reported on four studies of college students in which 45% to 68% of individuals had been involved in violent relationships and had both initiated and suffered from violence. Similarly, in their study of 185 adolescents in the 6th to 12th grades, Gray and Foshee (1997, p. 134) reported that 66% were both victims and perpetrators of violence in their dating relationships. Researchers who attempt to explain mutual violence suggest that it is more likely in adolescent relationships since both partners are still developing and neither has learned appropriate conflict management skills (Theriot, 2008). They also point to an increasingly violent society that promotes violence between individuals (Theriot, 2008).

Perpetrators in dating relationships use similar strategies as do those who are in long-term or marital relationships (Theriot, 2008). Adolescents who engage in dating violence have typically experienced violence in their own homes (White, 2009; Windle & Mrug, 2009). Observing violence or being abused in their homes provides negative role models for adolescents.

Prevention programs to reduce dating violence are being established, most of which have instructional curricula on issues such as conflict management and prosocial behaviors (Theriot, 2008). One such example is Safe Dates. "[The] Safe Dates program uses a 10-session educational curriculum combined with students' performance of a theatrical play about dating violence and creation of posters about preventing dating violence," according to Foshee and colleagues (1998), *Safe Dates* was implemented between the fall of 1994 and spring 1995, with 957 students in eighth grade. Foshee et al. (2004) conducted a 4-year longitudinal study to determine the long-term benefits of the program. Adolescents who had participated in the program showed less sexual and physical perpetration and victimization than students in the control group. They also showed less psychological abuse and victimization than those in the control group, although to a lesser degree (Foshee et al., 2004).

The *Connections: Relationships and Marriage* is another high school marriage-education curriculum that has shown positive results in reducing adolescent dating violence over a 4-year period (Gardner & Boellaard, 2007). *Connections* is a curriculum for youth in Grades 11 to 12. "The content of the curriculum aims to

fulfill the needs of today's youth for self-understanding and self-esteem, healthy dating relationships and values, effective communication and conflict resolution skills, and the awareness of skills needed to build a successful marriage" (Gardner & Boellaard, 2007, p. 493). Numerous lessons are included in the curriculum on issues such as characteristics of positive relationships, how dating behaviors relate to partner selection, how to establish clear expectations for self in dating relationships, and how to change negative statements into positive ones. Although long-term benefits over the control group failed to be maintained, dating and relationship violence did show a difference over the period of time (Gardner & Boellaard, 2007).

Financial Costs of IPV

The *Costs of Intimate Partner Violence Against Women in the United States* (National Center for Injury Prevention and Control, 2003) was funded by the Centers for Disease Control and the National Center for Injury Prevention and Control and reported by the Department of Health and Human Services. This section reports some of their findings.

The calculation of the financial expenses incurred by IPV can serve to (a) establish the impact of this problem, (b) provide needs assessment data to support changes in social policy and the creation of programs and services, (c) provide a basis on which to determine programmatic cost-effectiveness, and (d) bring into perspective the personal penalty each of us pays for these acts. The annual financial costs of IPV are estimated at $5.8 billion annually, which includes emergency care visits, outpatient visits, hospital stays, physician visits, dental visits, ambulance services, and physical therapy visits. The $5.8 billion calculation varies from $3.9 billion to more than $7.6 billion. Medical and mental health services are estimated at $4.1 billion, and lost productivity at $1.8 billion (National Center for Injury Prevention and Control, p. 32).

The negative consequences of IPV, both emotional and financial, are almost impossible to calculate. Consideration must be given to the destruction to families, intergenerational violence, professional prevention and intervention efforts, and involvement of the criminal justice system.

Summary

IPV can include physical, sexual, psychological, and economic abuse as well as stalking. Various theories exist to explain the occurrence of IPV.

Valid data are imperative for preventing and intervening in partner violence. Among the national surveys that have been conducted to date are the National Family Violence Surveys (Straus & Gelles, 1986), the National Crime Victimization Survey (Bachman & Saltzman, 1995), and the National Violence Against Women Survey (Tjaden & Thoennes, 2000). Despite the differences among these surveys, valuable information has been obtained as to the prevalence and incidence of IPV. The actual and related costs of domestic violence are astronomical.

Man Charged With Killing Girlfriend: Kenneth Beck Has Served Time for Domestic Assault

A man with a history of domestic violence who began a romantic relationship with a Warren County woman three months ago was charged in her death Tuesday.

According to police, Kenneth Wayne Beck, 34, quarreled Saturday night with his girlfriend, Stacie Hough, 33. The fight turned physical, and he strangled her with an electrical cord, police said.

Twenty hours later, Beck returned to the mobile home in the Oak Grove Trailer Court and called 911, saying someone had kicked in the front door, and he had found Hough dead in the master bedroom.

By Monday, Beck had changed his story and admitted he had killed his girlfriend, police said.

Members of the Major Case Squad of Greater St. Louis and Warren County Sheriff Kevin Harrison gave details of the case at a news conference Tuesday afternoon at the Warren County Courthouse.

Beck was being held there without bond on charges of first-degree murder and armed criminal action.

Police say Beck and Hough met three months ago, about the same time he was released from the St. Charles County Jail. He had been serving time on several misdemeanor charges, including domestic assault, property damage and theft, jail officials said. The stay was one of seven times Beck had been incarcerated in the St. Charles County Jail since 2001. He also pleaded guilty in 2005 to misdemeanor drug charges in Warren County and paid $350 in fines, court records show.

In 1999 and 2000, Beck had been in trouble in Minnesota, being charged there with felony terrorist threats and two counts of domestic assault, authorities say. He was sent to Missouri to serve out his sentence and apparently decided to stay here, according to officials with the Missouri Department of Corrections. It is unclear where Beck had lived previously.

Police say that Beck met Hough at the end of March and later moved in with her and her 4-year-old daughter. They shared a mobile home on a wooded lot in the 100 block of Dorry, south of Warrenton off Highway 47. The home is several hundred feet off the main road down a gravel drive.

Members of Hough's family were busy removing boxes of items from the mobile home Tuesday. They declined to comment.

Police say they had no record of any disturbances at the home before Beck reported the murder.

Hough was unemployed and was collecting disability payments for a back problem, police said. She was married but separated from her husband of eight years. Her husband now lives in St. Charles County and had been watching their daughter at the time of the murder, police said.

(continued)

A neighbor, Annabelle Houston, described Hough as "a pleasant person" who had stopped in to use her phone on several occasions.

Houston said she had been at home all evening Saturday but had not heard anything unusual over the sounds of the storm that swept through the area.

She said she had not been aware that Hough had separated from her husband or that Beck had moved into the home.

"What a tragedy." Houston said Tuesday. "I feel so sorry for that little girl. She was always with her mother." (Weich, 2006)

—Reprinted from the June 14, 2006, issue of the *St. Louis Post-Dispatch* (MO).

Discussion Questions

1. Which theories might be able to explain the relationship between Stacie Hough and Kenneth Wayne Beck in the above story?
2. What types of IPV did Stacie experience before the night of her death?
3. What were the opinions of various people around Mr. Beck before he killed Ms. Hough?
4. What could have been done to avoid this tragedy?

Key Terms

Dating violence
Gender-inclusive theories
Gender symmetry
Incidence
Intersectional feminism
Intimate terrorism
Mandatory arrest
Object relations theory
Postmodern feminist theory
Prevalence
Radical feminist sociocultural theory
Situational couple violence
Stalking
Violence Against Women Act

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Dynamics of Intimate Partner Violence

8

Fighting the Denial: Faith-Based Initiatives Are Raising the Shroud on Domestic Abuse

Kaye was a member of another congregation, a stranger when she visited Pat Merold, a pastor's wife with an empathetic ear. The mother of four told her story hesitantly at first, barely looking up.

For years, Kaye's husband called her fat and ugly. He brought women to their home for sex. He didn't even try to hide it.

Kaye eventually mustered the courage to tell her minister what was happening.

(continued)

But the minister belittled her pain. He said her husband, a church elder, was a good man. She just needed to be a better wife, he explained, then things would get better.

As she repeated her minister's advice, Kaye's quivering chin gave way to sobs.

Merold's husband was pastor of a California church about 25 years ago when Kaye confided in her. It was the first time an abuse victim had come to her for help.

"What I learned was that these things do go on among people that go to church, and we have to listen," said Merold, who moved with her husband, Ben, in 1991 to Harvester Christian Church in St. Charles.

For many reasons—often ignorance or denial—religious leaders struggle with how to respond to domestic abuse. Their focus is to keep families together and protect marriages, which, at times, can put their good intentions at odds with protecting victims, say advocates and some clergy members.

Yet clergy can be a powerful authority in challenging abusers, who sometimes falsely use religion to justify their abuse, research shows. Clergy also can be a source of physical and spiritual healing for victims.

Initiatives nationwide and locally are helping clergy to realize their unique role in combating domestic abuse and to respond to victims appropriately. The first step, advocates say, is to recognize that victims are in the pews.

Kaye eventually joined Merold's church. Within a couple years, Kaye moved to another state to escape her husband.

Merold didn't know it at the time, but Kaye's ordeal was the first lesson in what would become her calling—to be a faith leader who listens and gives victims hope.

"It's the lowered eyes, the sense of shame that grabs my heart," Merold said. (Munz, 2008)

—Reprinted from the July 11, 2008, issue of the *St. Louis Post-Dispatch* (MO).

As the article reflects, even seemingly "good people" can be perpetrators of intimate partner violence (IPV). Perpetrators and victims are often difficult to identify because their home life appears "normal" to outsiders. Understanding the basic dynamics of IPV can help in identifying and understanding this complex problem. This chapter discusses issues of power, the cycle of violence, learned helplessness, the battered woman syndrome, and reasons victims stay in abusive relationships.

Dr. Lenore E. A. Walker (1979, 1984) first proposed many of these concepts, and after 30 years, the conclusions she reached still hold up (2009, p. 5). Her third edition of *The Battered Woman Syndrome* (2009) is highly recommended for readers wanting to learn more about intimate partner violence.

Power and Control

Violence within intimate relationships is typically explained as one partner's abuse of power for the purpose of controlling the other (see Chapter 7). The strategies used are visually captured with the **Power and Control Wheel**, which was created by the Domestic Abuse Program in Minneapolis in 1982 as part of a psychoeducational approach for stopping violence (see Figure 8.1). This model is based on the feminist perspective that men are the perpetrators of abuse against female victims. The program used a combination of punishment and rehabilitation. It became known as the "Duluth model" and is still widely used in many batterer intervention programs. The spokes of the wheel represent various strategies used by the perpetrator to control the victim while misusing his power: (a) intimidation, (b) emotional abuse, (c) isolation, (d) minimization and denial of the abuse while blaming the victim for his actions, (e) the misuse of children, (f) male privilege, (g) economic abuse, and (h) coercion and threats (Dutton & Starzomski, 1997; Pagelow, 1997; Walker, 2002).

Within a more equal relationship, each partner has power and the ability to control the other. This type of relationship is represented by the **Equality Wheel** (see Figure 8.2) characterized by strategies of (a) nonthreatening behavior, (b) respect, (c) trust and support, (d) honesty and accountability, (e) responsible parenting, (f) shared responsibility, (g) economic partnership, and (h) negotiation and fairness.

In this relationship, both partners feel safe—free to communicate and express their thoughts and feelings to one another.

Since the creation of the power and control wheels, numerous adaptations have evolved to represent various populations, such as same-sex couples, immigrant families, and children living in violent homes (see Chapters 10, 11, and 13). The power and control wheels offer quick snapshots of complex strategies and thus can be effective for didactic purposes. Intimate partner violence (IPV) "is still considered learned behavior that is used mostly by men to obtain and maintain power and control over a woman" (Walker, 2009, p. 5). In the sparse literature addressing IPV between gay men and lesbian partners, the use of IPV is "to obtain power and control over one's partner . . ." (Walker, 2009, p. 5).

Cycle of Violence

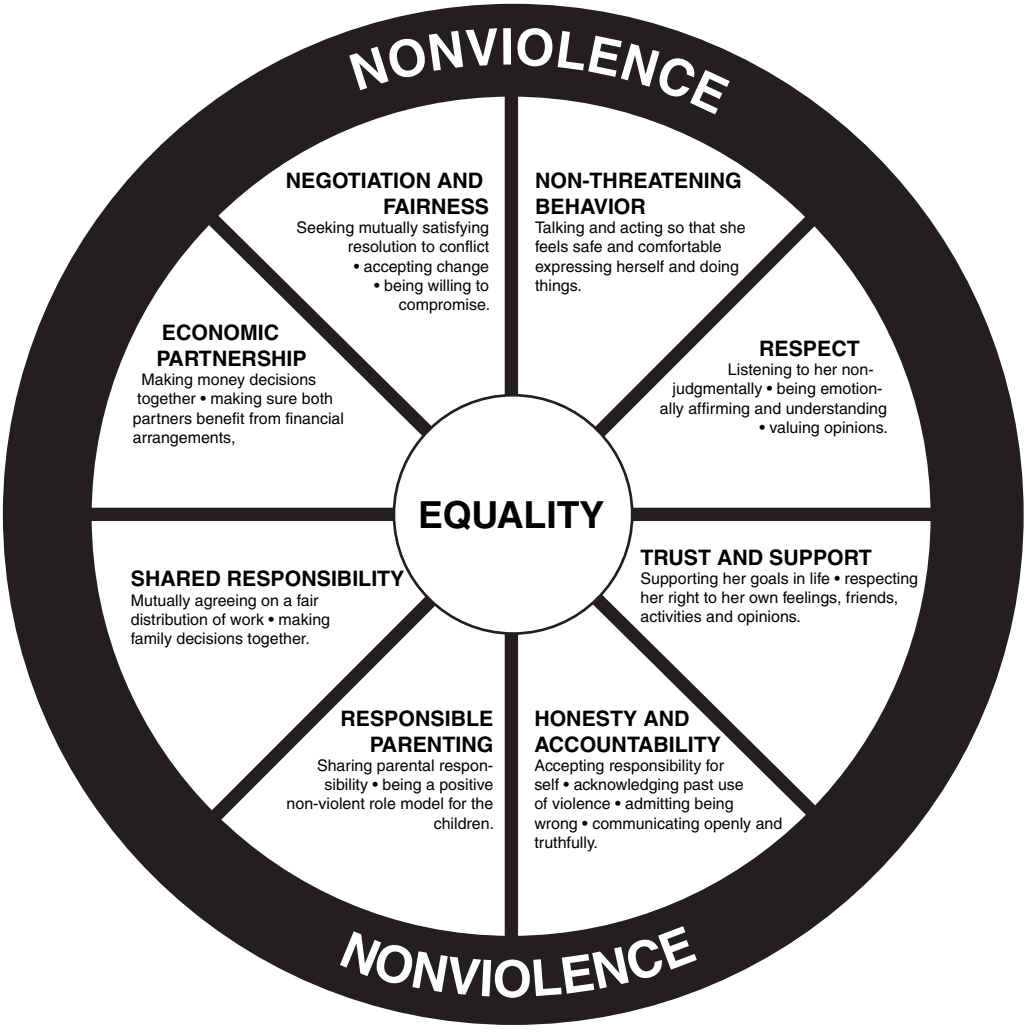
Perpetrators of partner violence typically implement strategies of power and control in a three-phase pattern referred to as the **cycle of violence** (Walker, 1979). This circular pattern moves from the tension-building phase to the actual abuse (using one of the strategies represented within the power and control wheel). Following the incident, perpetrators typically enter a stage of remorse and loving contrition during which they promise never to repeat the abuse (Walker, 2009). As the cycle continues, the abuse becomes more frequent and more severe. Eventually, the remorse stage disappears. This phenomenon is called the *cycle of severity* (Walker, 2009, p. 409).

8.1

Power and control wheel. From *Power and Control Wheel,* by Domestic Abuse Intervention Project. (n.d.). Duluth, MN: Author.

8.2

Equality wheel. From *Equality Wheel,* by Domestic Abuse Intervention Project. (n.d.). Duluth, MN: Author.



Learned Helplessness

Victims' inability to remove themselves from abusive relationships has been attributed to **learned helplessness** (Walker, 1984). In the 1960s, various experiments were conducted to determine how subjects cope with perceived inescapable adverse circumstances. In one famous set of experiments, dogs were harnessed inside a box and then given an electric shock. At first, because of the harness, escape was impossible. In time, the harnesses were removed; however, even when the dogs were free to escape, they did not try. The researchers theorized that the dogs had succumbed to a belief that efforts to escape were in vain; thus they learned they were helpless to control the outcome of their behaviors (Overmeir & Seligman, 1967).

Later experiments attempted to determine if learned helplessness generalized to humans. Humans were presented with irritating noises and unsolvable problems. The more the humans failed to escape the noise or to solve the problems, the less they tried (Abramson, Seligman, & Teasdale, 1978). Based on these results, researchers concluded that humans, like dogs, learn to be helpless when placed in seemingly inescapable situations.

Based on the results of her research, Walker (1979) proposed that victims of IPV also suffer from learned helplessness. This is not to say that victims are helpless; rather, it means that they have lost the ability to predict the outcome of their actions (Walker, 2009, p. 69). Instead of trying to control their situation, they develop sophisticated coping strategies to survive it. Learned helplessness suggests a reason why some women stay in abusive relationships until they resort to acts that might seem excessive to individuals with no experience of abuse (Walker, 2009).

Bargi, Ben-Shakhar, and Shalev (2007) studied the relationship of learned helplessness (LH), **posttraumatic stress disorder** (PTSD), and major depression (MDD). PTSD is frequently diagnosed in battered women; it develops because of their abusive situation and often co-occurs with MDD (Bean & Moller, 2002). Battered women who acquire LH tend to be at high risk of developing PTSD and MDD (Bargi et al., 2007); their development of LH is associated not only with their abusive situation but also with past difficult life circumstances. These circumstances include past abuse (perhaps as children), low education, and past cultural influences such as the belief in male supremacy (Bargi et al., 2007; Jewkes, Levin, & Penn-Kekana, 2002). LH in battered women can be reversed with treatment (Bargi et al., 2007; Walker, 2009). Treatment requires attention to victims' biological, physiological, and psychological state as well as an empowerment approach to reduce their LH, PTSD, and MDD (Bargi et al., 2007).

The use of the term *learned helplessness* is somewhat controversial because it implies that victims of IPV are helpless, yet they are not and should not be treated as if they were (Walker, 2009). To the contrary, many victims try to leave their abusers, only to return for rational reasons such as fear of being killed if caught escaping, fear of retaliation, inability to provide for their children, love for the perpetrator, or religious beliefs (Weitzman, 2000). Victims may choose to stay because of shame, disbelief that abuse is happening, and/or fear of losing financial comforts (Weitzman, 2000). For social workers, victims' self-defeating

characteristics that brought them into their abusive relationships are not so important as helping them overcome those feelings and escaping the violence.

The Battered Woman Syndrome

Lenore E. A. Walker (1984) proposed the concept of the **battered woman syndrome** (BWS), which

> *Consisted of the pattern of the signs and symptoms that have been found to occur after a women has been physically, sexually, and/or psychologically abused in an intimate relationship, when the partner (usually, but not always a man) exerted power and control over the woman to coerce her into doing whatever he wanted, without regard for her rights or feelings. (Walker, 2009, p. 42)*

The BWS can be identified through six criteria; the first three are also symptoms of PTSD (Walker, 2009, p. 42). People experiencing BWS fear for their lives; this activates the fight-or-flight response, and they must decide whether to cope with the problem or escape. Second, the experience and effects of this trauma last for more than 4 weeks. Third, the effects impact important parts of their lives, such as job performance (Walker, 2009, p. 46).

BWS has three more criteria (which are not shared with PTSD). Women experiencing BWS feel disruption in interpersonal relationships, and they experience many forms of manipulation such as "isolation, following his rules, sex, degradation, jealousy, unpredictability, and direct and indirect threats of more violence" (Walker, 2009, p. 65). Next, women with BWS have significant difficulties with body image. In addition to not liking their bodies, they have somatic symptoms, including asthma and fibromyalgia. The final criterion are that women with BWS develop sexual intimacy issues.

Among early depictions of BWS that drew attention to the plight of the battered woman was that of Francine Hughes and Lorena Bobbitt (Walker, 2002). In 1980, *The Burning Bed: The True Story of Francine Hughes—A Beaten Wife Who Rebelled* was published by Frances McNulty (1980). The story was about Francine Hughes, who, after 13 years of abuse, tied her husband to a bed, escaped with the children, and burned down her house with her husband in it (Walker, 2002). In the 1990s, Lorena Bobbitt was brutally raped by her husband, John Wayne Bobbitt. In desperation, she cut off her husband's penis, which was later found and surgically reattached (Walker, 2002).

Neither of these women was able to use the BWS as a defense because the courts were not yet receptive to it. Instead, both were found "not guilty by reason of insanity" (Walker, 2002, p. 90).

> *In a series of opinions . . . the American Psychological Association . . . finally declared that there was scientific evidence that there was a body of psychological knowledge that could both identify the psychological effects of domestic violence and determine whether the dynamics of a battering relationship existed. (Walker, 2002, p. 91)*

With an increasing number of similar cases coming to the attention of the courts, the National Clearinghouse for the Defense of Battered Women was established in Philadelphia in 1987 to assist battered women who were wrongfully imprisoned for killing their perpetrators. This organization continues to provide education, resources, and legal defense to imprisoned victims of abuse (www.ncdbw.org).

Why Victims Stay

The dynamics of domestic violence are so complex that it is difficult for most people to understand why a woman living in an abusive relationship does not simply leave. Many of the common explanations for why victims stay are myths. One myth is that victims are masochists who are purposely trying to hurt themselves. In truth, victims may stay because they either believe that they deserve blame or are unaware of any alternative. However, they do not purposely want to suffer a lifetime of abuse.

There are a multitude of reasons why victims stay in their destructive relationships. Every part of their lives is intermingled with that of their perpetrator, including emotional, cognitive, financial, physical, cultural, and spiritual factors (Dutton & Starzomski, 1997; Pagelow, 1997; Walker, 2002). Emotional reasons include their love for their perpetrator. Cognitively, they may believe in their perpetrator's willingness to change. Even if they reach the point that they no longer believe and decide they want to leave, they may either be embarrassed about the abuse or fear being alone after escaping. Victims who are emotionally or mentally challenged may be unable to formulate an escape plan or to comprehend the abusive lifestyle in which they are living.

Financially, victims may need to stay in the abusive relationship. They may lack transportation that would enable them to leave. Either they or their children may depend on the perpetrator for basic necessities such as health insurance. Victims may be unemployed, on welfare, lack education, or in some other way be economically dependent on their perpetrator.

Children are another common reason why victims stay. Victims may believe that children require a two-parent family. Unfortunately, victims seldom comprehend the damaging impact that witnessing partner violence has on children (for more on child witnessing of partner violence, see Lundy & Grossman, 2005 and Wolak & Finkelhor, 1998). However, if victims finally decide to leave their abusive situations, they may risk losing custody of their children. The courts can misinterpret their efforts to leave as deserting their families.

Victims' culture, ethics, and religious beliefs also come into play. Victims who were raised in an environment that valued men and denigrated women may believe that abusive treatment is common. Or they may not leave because they fear public humiliation.

Victims may choose to stay with perpetrators for fear of their lives. "Nearly one-third of female homicide victims reported in police records are killed by an intimate partner" (Department of Health and Human Services, 2003, p. 3). Violence against women is a substantial public health problem. Relatively few victims or near victims of homicide by intimate partners overestimate their danger; in fact, they tend to underestimate the danger (Campbell, 2004). Leaving an abusive partner may only tend to increase this danger (Eigenberg,

2001) This increase in perpetrators' dangerousness must be taken seriously by victims planning to escape, by law enforcement providing protection, and by social workers assessing the family (Lyndon, White, & Kadlec, 2007).

The question should not be "Why does she stay?" but rather "Why doesn't the batterer let her go?" (Walker, 2002, p. 94). Questioning victims' behaviors can be identical with blaming them. Social workers and other professionals need to identify victims, give them the resources they need in order to leave, and protect them from further abuse. Stopping family violence requires the commitment of all members within a community as well as society.

Summary

The dynamics of intimate partner violence are commonly depicted and described by the power and control wheel, the cycle of violence, learned helplessness, and battered woman syndrome. These dynamics offer a helpful view into partner violence and its impact on families.

The various power and control wheels explicate the strategies used by perpetrators against their victims. These strategies are usually displayed in timed phases commonly referred to as the tension, explosion, and contrition stages. The pattern was originally called the cycle of violence; however, other terms are also used, such as the spiral of violence.

Victims stay in abusive relations for a multitude of reasons. Learned helplessness describes a condition in which victims feel they are unable to escape their perpetrators and thus resign themselves to the abusive situation. Some victims strike out against their perpetrators in the psychological state of the BWS. This, too, is a term under contention and must be used judiciously on behalf of victims.

Some perceptions people have as to why victims stay with their perpetrators are real while others are myths. Social workers are responsible for differentiating among these reasons, being mindful that the most important reason is the victim's perception of her situation; that is her reality.

Domestic Violence Impacts Pets, Too

One man lined up his family in the driveway of their rural Nebraska home. Wife first, children in order by age next, dog last. Then he shot the dog.

Another would stand next to a pot of boiling water, holding his wife's tiny dog. She got the message.

A fourth hid his partner's pet bird every time he left home, knowing she would not leave him without taking the bird.

Such cases—all occurred in Nebraska—aren't new to people who work in domestic violence and animal care. They've known for years that animals suffer along with people when family relationships become abusive.

(continued)

"I've been doing this 25 years, and I've heard some pretty horrific stories," said Kay Mathews, development director for Lincoln's Friendship Home, a shelter for abused women and children.

"In domestic violence, pets very often are used as a weapon," Mathews said. "It's a tool."

Now laws spreading across the country aim to give victims of domestic violence their own tool to protect themselves and the animals they love.

The laws allow people seeking protection orders for themselves to have their pets included on those orders. Judges can require abusers to stay away from the animals or risk arrest. Judges also can give temporary custody of pets to the person seeking the order.

Ten states—Maine, Vermont, Colorado, Tennessee, Louisiana, Illinois, Connecticut, New York, California and Nevada—now have such laws.

Iowa and seven other states are considering similar measures, according to the American Humane Association.

A proposal was introduced in the Nebraska Legislature this year but stalled last week. Legislative Bill 83, offered by State Sen. Amanda McGill of Lincoln, fell one vote short of advancing to the second round of debate.

Opponents of the Nebraska measure argued that it would elevate animals to the level of children and other household members.

They also expressed concern that the proposal was an effort by animal rights groups to push their agenda in Nebraska, with an eventual goal of restricting how farmers raise cattle, hogs and other livestock.

Backers of the measure said it could help victims of abuse, who are typically women, escape their situation. Concern for pets can keep people from leaving a violent situation, just as concern for pets kept people from fleeing Hurricane Katrina and other natural disasters.

"Some people will sacrifice their life to protect their children and their pets," said Bob Downey, executive director of the Capital Humane Society in Lincoln." (Stoddard, 2009)

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Discussion Questions

1. Apply the basic theories discussed in this chapter—power and control, cycle of violence, learned helplessness, battered woman syndrome (BWS), and reasons women stay—to Kaye's story in the beginning of the chapter.
2. What is your opinion as to the validity of the BWS?
3. What is your opinion as to the legislative action of making animals eligible to be protected with a restraining order? What are its benefits? What are its problem areas?

Key Terms

Battered woman syndrome
Cycle of violence
Equality Wheel
Learned helplessness
Posttraumatic stress disorder (PTSD)
Power and Control Wheel

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The Criminal Justice System and Intimate Partner Violence

9

Court Gets Tough on Domestic Abuse

Judge Michael Burton knew he had a problem when the woman, barely 5 feet tall, begged him to order her 300-pound boyfriend to stay away from her. She said he had pushed her and told her he wanted to kill her.

Burton, the St. Louis County family court judge, recalled asking the boyfriend if it was true: Did he think he wanted to kill her?

The man answered, he didn't "think" he wanted to kill her. "I promise to kill her."

"That was one of those moments," Burton recalled. "I thought, I'm not doing enough."

(continued)

> Later this month, Burton's civil court will retool the way St. Louis County handles its domestic violence cases to better protect victims and monitor its alleged abusers and stalkers. After years of complaints that the court was often ineffective, Burton is instituting the one-year pilot program based on the recommendations of a group of about 40 people that included victims advocates, attorneys and police.
>
> "We're hoping word gets out that we are addressing domestic violence differently, and because of that we are expecting to see an increase in filings," Burton said.
>
> The changes, which will still need long-term funding sources to implement beyond next year, aim to strengthen orders of protection, penalize those who break them, connect the abused and their children with services and advocates, and weed out less serious disputes from potentially fatal domestic situations.
>
> Christine Hustedde, interim director of Legal Advocates for Abused Women, said the court should set an example for the community.
>
> "There is still the belief out there that people have the right to abuse their partner." (Cambria, 2009)
>
> —Reprinted from the March 3, 2009, issue of the *St. Louis Post-Dispatch* (MO).

"There have been a plethora of suggested remedies for the problems posed by domestic violence" (Etter & Birzer, 2007, p. 114). Solutions include formal sanctions (mandatory arrests for abusers) and informal sanctions (counseling abusers). The Protection from Abuse Order (PFA) is one of these sanctions (Etter & Birzer, 2007). This chapter addresses orders of protection, the process for obtaining them, the debate as to their effectiveness, mandatory arrest and no-drop policies, and social workers' responsibilities within this system.

Orders of Protection

Approximately every 18 seconds, an act of intimate partner violence (IPV) occurs (Paisner, 1989). Annually, an estimated 5.3 million IPV victimizations occur among women ages 18 and older (Department of Health and Human Services, 2003). Nearly 33% of all reported murders of females are committed by an intimate partner (Department of Health and Human Services, 2003). Even though, historically, less than 10% of IPV incidents are reported to police authorities (Buzawa & Buzawa, 1997), domestic battering is among the most common form of violence (McNeely, Cook, & Torres, 2001).

In 1976, to protect victims from partner violence, some U.S. courts began issuing *orders of protection* (Postmus, 2007): by 1989, all 50 states and the District of Columbia had legislation authorizing these orders (Postmus, 2007). Orders of protection are intended to prevent abusers from coming into contact with their victims. Most states allow a broad spectrum of persons to apply for

protection, including those who are married, divorced, living together (presently or in the past), related by blood, have a child together, and/or have reason to believe they are endangered by another (Postmus, 2007). Stipulations in the order can restrict contact, "possession of the house; financial support; court costs; referrals for counseling; custody, visitation, and support of children" (Postmus, 2007, p. 348). Other stipulations can be included, such as not being allowed near (within 500 feet of) the victim or victim's family and friends; no stalking or harassing; no calling on the phone, sending letters, or e-mailing; no contact of any types; and no carrying of a firearm (Karan & Lazarus, 2003; Postmus, 2007).

Although all states issue orders of protection, the terminology used may differ. Other terms for orders include **civil protection orders, restraining orders**, and **injunctions** (Capshew & McNeece, 2000). Some state courts have different charges for different violations, depending on the relationship between the parties and the committed acts (domestic violence, repeat violence, dating violence, or sexual violence; Karan & Lazarus, 2003). Despite these differences, sufficient similarities exist in the processes for obtaining and enforcing orders of protection to provide information that is broadly applicable (Karan & Lazarus, 2003).

The 1994 Violence Against Women Act I (VAWA) enabled federal courts to prosecute IPV crimes across interstate lines and violations of civil protection orders as well as to impose enhanced sentences on defendants convicted of federal crimes (Abolfazli, 2006). From a feminist perspective, the statute recognized gender-motivated violence even if criminal charges were not filed (Abolfazli, 2006). VAWA II, passed in 2000, changed any requirement for a victim of IPV to report to the state register or to the perpetrator before crossing state lines, thus protecting victims who are trying to escape from their abusers. VAWA II also allowed immigrant women and their children to escape deportation if they were victims of IPV, thus making their escape from the perpetrators easier (Abolfazli, 2006).

The Court System

An overview of the government branches, laws, and court systems is presented in Chapter 4; this section reviews the same topics as a basis on which to discuss the criminal justice system and IPV. The U.S. Constitution divides the federal government into three branches: (a) the executive branch (president and vice president); (b) the legislative branch (congress); and the judicial branch (federal courts). Likewise, state constitutions divide their governments into three branches: the executive (governor), legislative (state congress), and judicial (state courts).

Laws are rules that determine how members of society are to behave (Brayne & Carr, 2008). In the United States, laws are established by federal and state governments through three methods: regulations, statutes, and court decisions (Myers, 1998). Regulations are established by the agencies of the executive branch and are set forth in the Code Book of Federal Regulations or state administrative code books, respectively. Statutes are referred to as "public laws," which are passed by congress; one example of a federal statute is the Violence Against Women Act (VAWA). State statutes create domestic violence

agencies, civil courts, and other social agencies (Myers, 1998, p. 47). Court decisions, which are referred to as common laws, are legal decisions made by judges in cases where no legal precedent exists (Myers, 1998).

The judicial system comprises two primary types of courts: civil and criminal. Civil courts hear cases that do not involve the breaking of criminal laws, but rather address issues such as contract disputes, property damage, minor injuries, and compensation from accidents (Brayne & Carr, 2008); these are the courts that handle orders of protection. Specific types of civil courts are *family courts* and *juvenile courts*.

Protection orders can be filed in other courts depending upon the circumstances.

Family courts commonly hear divorce, child support, and child custody cases (see also the discussion of juvenile courts in chapter 4). If a person seeking an order of protection is already involved in family court (for example, in a custody dispute), then the court judge can also handle the order of protection (Brayne & Carr, 2008). The victim's attorney can request the order. The judge, typically with assessment information provided by social workers or other professionals, makes the final determination as to whether or not an order of protection should be granted, and if so, with what (if any) stipulations (Postmus, 2007).

Criminal courts are responsible for determining the innocence or guilt of persons charged with misdemeanors and felonies. Acts of IPV can be either of these, depending on the decision of the prosecuting attorney in filing charges (Worrall, Ross, & McCord, 2006). Felony charges are more apt to be filed if the assault was sexual or resulted in serious injury and if the victim requests that charges be filed (Worrall et al., 2006). Persons do not need to have a criminal charge against them to have an order of protection filed against them; however, criminal courts can issue orders of protection if respondents (alleged abusers) have a criminal charge against them.

The Process

A petition for an order of protection can be filed by any adult (a person 18 years and older, or anyone who is legally emancipated). The person filing the request is the **petitioner**. To file, the petitioner must have been a victim of IPV or have reasonable cause to believe that he or she is in imminent danger of becoming a victim (this includes stalking; Karan & Lazarus, 2003). The person who is named as the alleged perpetrator, legally called the **respondent,** can include a present or former spouse, intimate partner, the parent of the petitioner's child, or other adult with whom the petitioner had a relationship. (When the charge is *stalking,* the respondent can be any adult.) Both men and women can file petitions; however, in most cases, the petitioners are female victims of male perpetrators (Basile, 2005). Sample order of protection forms from various states can be found at the FindLaw website (http://family.findlaw.com/marriage/marriage-more/state-domestic-violence-forms(1).html).

When completing the petition, petitioners are asked to provide as much information as possible, such as description of the acts of assault, battery, coercion, and/or harassment; dates of the occurrences of these offenses; names of witnesses; and other information that can establish evidence to support the accusations. Documents such as pictures of the abuse and hospital records are

also requested. Usually, the courts do not request a fee for filing a petition. No residency requirements exist, which helps petitioners who are trying to escape from an abuser by enabling them to file in another area than where they reside (Basile, 2005).

At the initial **ex parte hearing**, the plaintiff (petitioner/victim) can appear before the judge without the defendant (respondent/alleged abuser), to request a temporary restraining order or temporary order of protection (18 U.S.C. Statute 2266; Basile, 2005). The judge renders one of three decisions. He or she can deny the request, at which time the case is closed, or defer the request, at which time a 10-day hearing is scheduled, where the case is presented with the defendant present. Or the judge can grant the **ex parte order of protection,** at which time the 10-day hearing is scheduled (Basile, 2005). In rare occasions, the 10-day hearing can be conducted immediately (Basile, 2005).

This temporary ex parte order is typically enforceable for roughly 10 to 14 working days, pending a court hearing for a permanent order of protection (Basile, 2005). Plaintiffs are instructed to keep the petition readily available in the event that they need to call the police for help. After the judge grants the temporary order, law enforcement officers serve papers on the respondent, which orders him or her to appear at the next scheduled court hearing (Basile, 2005).

At this second protective order hearing (also referred to as the **10-day hearing** or **evidentiary hearing**), both the plaintiff and respondent present their cases (Basile, 2005). If the judge determines that a preponderance of evidence exists (i.e., more weight of evidence to believe than not to believe) to support the plaintiff's accusations, the judge issues a permanent order of protection (Abolfazli, 2006; Etter & Birzer, 2007; Karan & Lazarus, 2003; Yearwood, 2005). This order is intended to prevent the respondent from contacting or stalking the victim. The defendant may not enter the petitioner's residence, place of employment, or other places in which the petitioner regularly appears, such as the home of a family member. The order can include provisions for counseling, custody, and child support. Multiple stipulations can be included to assure the victim's safety from any further abuse or harassment (Karan & Lazarus, 2003; Postmus, 2007). The order is enforceable for approximately one year unless the victim withdraws the order through the court process (Abolfazli, 2006).

Reciprocity exists among all states; thus, all states will legally recognize and uphold an order of protection. The criminal court system acts on any violations, regardless of the state in which the order was filed or the state in which it was violated (Abolfazli, 2006). Orders are also enforceable throughout Indian tribal lands, District of Columbia, U.S. Virgin Islands, Puerto Rico, American Samoa, Northern Mariana Islands, and Guam. Victims are asked to carry a certified copy of the protection order containing the stamp, seal, and signature of the issuing judge at all times (Abolfazli, 2006).

In 2005, in *United States* v. *Morrison* (Abolfazli, 2006), the Supreme Court ruled that law enforcement officers cannot be held liable for damages for failing to enforce a court-issued order of protection. In 2000, Jessica Gonzales filed a $30 million lawsuit against the town of Castle Rock, Colorado, stating that the police failed to enforce a restraining order against her estranged husband, Simon Gonzalez (Greenhouse, 2005). In 1999, Ms. Gonzales had obtained a restraining order that limited her ex-husband's contact with their children. He

was playing with the children (ages 7, 9, and 10) outside his ex-wife's house when he disappeared with them. He called Ms. Gonzales to say that he was at an amusement park. Ms. Gonzales repeatedly called the police department asking them to bring her children home. Hours later, Mr. Gonzales arrived at the police department with the bodies of the children in the back of his truck, firing a gun at police. He was killed at the scene. When the case reached the Supreme Court, it ruled that the law enforcement officers involved were not liable (Abolfazli, 2006; Greenhouse, 2005). "Despite [this] major setback handed down by the Supreme Court, domestic victim advocates have continued the fight for more protection and understanding for victims of domestic and sexual violence" (Abolfazli, 2006, para. 12).

Mandatory Arrest

Following the 1981 and 1982 Minneapolis Domestic Violence Experiment (MDVE; Sherman & Berk, 1984), "most states and police departments nationally have implemented proarrest policies," according to Hendricks (as cited in Eitle, 2005, p. 574). Mandatory arrest policies require that, upon being called to a domestic dispute, the police will arrest suspects rather than counseling them or making them leave the premises (Sherman & Berk, 1984).

> *Although recent research has begun to develop an established set of situational variables that predict arrests in domestic violence cases, there has been very little research that has examined police organizational variables and their association with arrest probabilities in domestic violence cases. (Eitle, 2005, pp. 573–574)*

Before mandatory arrest policies were implemented, "the probability of arrest in IPV cases ranged from 3% (Langley & Levy [as cited in Eitle, 2005, p. 575]) to 14%" (Bayley [as cited in Eitle, 2005, p. 575]). In 2000, arrests were reported at 30% (Robinson & Chandek, 2000).

Eitle (2005) collected data from 115 police departments on 53,716 IPV cases to determine the influence of mandatory arrest policies in actual arrests on these cases. Independent variables included situation variables (such as extent of injury to the victim, whether a weapon was involved, and age and race of offenders), contextual variables (such as whether the police had a mandatory arrest policy for IPV cases and whether they had a special domestic violence unit), and structural complexity (such as organizational size). Eitle (2005) reported that 76% of the departments had mandatory arrest policies; 19% had specialized domestic violence units; 83% of the cases involved male suspects and female victims; and in 49% of the cases, an arrest was made. The probability of arrest increased if injuries were sustained, weapons were involved, substance abuse was evident, and cases occurred indoors. Black victims and younger victims were less likely to have cases result in arrest; "mandatory arrest policies appear to reduce the importance of victim age and arrest risk" (Eitle, 2005, p. 588). Arrests increased where mandatory arrest policies existed, where crime rates were high, and departments were centralized (having many written directives).

Eitle (2005) concluded that mandatory arrest policies increase the risk for arrest in IPV cases; however, arrests were made in only half the cases in the study. Arrests increase with more complex organizations that have extensive written policies in place. Under mandatory arrest policies, African American suspects are less likely to be arrested than White suspects. However, more research is needed as to the variables determining the decisions to arrest.

In 2005, Townsend, Hunt, Kuck, and Baxter studied 732 police departments (a randomly selected, nationally representative sample) as to their response to IPV calls. Findings included that (a) 77% of police departments had written operational procedures for responding to IPV calls; (b) some variation existed in the procedures covered in written policies (e.g., only 41% had procedures on how to interact with victims); (c) some variation existed in what departments required dispatchers to do when responding to emergency calls (e.g., 54% to check on the presence of protection orders, and 44% to check on warrants associated with the address); (d) variation existed in what departments required call takers to do (e.g., 61% ask about weapons; 52% stay on line until police arrive; 47% ask whether children are present; 46% ask whether the suspect uses drugs/alcohol); (e) officers followed a range of activities when answering a domestic call (e.g., 90% required officers to interview the victim separately from the abuser; 28% reviewed a safety plan with the victim); (f) 74% required officers to receive specialized domestic violence training; and (g) 86% of departments required written justification when no arrest is made and when both parties are arrested.

The report concluded that most police departments have sufficient policies and procedures for call takers and dispatchers but that the officers needed more guidance on how to handle difficult IPV calls. Further, officers need more training on IPV, and officers need additional guidance on calls to reduce their discretion (Townsend et al., 2005).

No-Drop Policies

The 1992 VAWA required "prosecutors to pursue a charge if there was sufficient evidence and regardless of whether the victim wanted to pursue the action or not" (Abolfazli, 2006, para. 8). This **no-drop policy** was passed on the belief that aggressive prosecution was necessary to stop IPV (Worrall et al., 2006). Prosecuting attorneys "decide who is charged, whether a plea bargain will be offered or accepted, and what evidence will be presented should a case go to trial . . . [and] offer sentencing recommendations when a case results in a guilty verdict" (Worrall et al., 2006, p. 472–473).

Originally, no-drop policies were passed partly under the assumption that victims of IPV would change their minds and either withdraw their petition or not appear in court, thus, they would "clog the system and waste the court's time and energy" (Postmus, 2007, p. 350). Victims would often file the initial petition to have the ex parte order served on their abuser; however, they would not appear for the second hearing (Erez & Belknap, 1998). Victims' reasons for not returning to court include that the abuser was not served with the ex parte order, so he would not be present at the second hearing. However, according to Quarm and Schwartz (as cited in Erez & Belknap, 1998, p. 254), "research has found that

the main reason battered women drop their cases is fear of reprisal. (Revictimization was highest for the more severe abuses, and "victims reported incessant threats, abuse, confusion and pain" (Erez & Belknap, 1998, p. 263). Alternatives to mandatory arrests, and the automatic consequences of these arrests, should be explored to assure victims' safety and over-all well-being (Postmus, 2007).

Worrall et al. (2006) gathered data from 245 crime reports filed by police officers in 2003 on IPV cases in various parts of Southern California. Data were organized into case characteristics (such as whether an arrest was made at the scene, whether a weapon was used, and whether the victim was seriously injured), victim characteristics, and suspect characteristics (such as gender, ethnicity, relationship to victim, and age). The study found that prosecutors filed criminal charges in 96 (39%) of the cases and that charges tended to be filed when there was serious injury, there was an arrest at the scene, the victim was female, the suspect had been drinking, and the victim wanted charges to be made. Whether the prosecutor filed a misdemeanor or felony was partly determined by the seriousness of the injury. A serious injury would result in a felony charge. Worrall et al. (2006) recommended that more research be conducted as to the decision making by prosecuting attorneys in IPV cases.

Effectiveness of IPV Policies

While the criminal justice system has greatly increased its understanding of IPV and how best to respond to it, there are still many questions about effectiveness of orders of protection, mandated arrests, and the no-drop policies. The extent of effectiveness depends on various systemic issues including characteristics of the victims, typology of the perpetrators, training of law enforcement, and attitudes of the courts (Erez & Belknap, 1998; Fleury-Steiner, Bybee, Sullivan, Belknap, & Melton, 2006; Postmus, 2007).

Fleury-Steiner and colleagues (2006) gathered data from 178 women who had filed IPV charges in the midwestern or western United States to determine their experiences with the legal system. Most of these women were interviewed shortly after their court appearance and periodically throughout the year following. It was found that almost one in five (19%) of the women were physically assaulted during this time. The two major negative indicators of women reusing the system were their legal and financial ties to the abuser. Women who were living with their abuser and who depended on his income did not intend to reuse the system. Others who did not intend to reuse the system were women who had been dissatisfied with their treatment, severely abused before the arrest, and revictimized while the case was in process. The women who were generally satisfied with their experience were employed and economically self-sufficient. They had solid support systems, both personal and professional. Fleury-Steiner and colleagues concluded that socioeconomic status can have a strong impact on victims' experiences within the criminal justice system.

According to Eigenberg and colleagues (as cited in Postmus, 2007, p. 352), "Complaints about the ineffectiveness of restraining orders include the lack of enforcement of violations, ineffectiveness in deterring batterers from abusing, and further aggravation of the abusers." On the other hand, orders of protection are effective in empowering women to end abusive relationships and increasing

the responsiveness of the police (Chaudhuri & Daly, 1992). They are not effective when it comes to having the abuser arrested. They have little effect in determining whether a woman is revictimized by the same abuser (Chaudhuri & Daly, 1992). One of the principal challenges to increasing the effectiveness of orders of protection lies in improving law enforcement's response when the abusers violate the orders (Postmus, 2007).

Mandatory arrests, although intended to protect victims, have conflicting outcomes. At times, victims may feel empowered by the arrest because they have proven to themselves that they have the power to stop the abuse (Postmus, 2007). In other situations, victims feel disempowered; their ability to make any decision as to what will happen, both at the time of the arrest and following the arrest, has been removed (Erez & Belknap, 1998).

Frye, Haviland, and Rajah (2007) gathered data from 183 callers to a telephone helpline for victims of IPV in New York to explore the unintended effects of mandatory arrest policies. Unintended effects included dual arrest (both male and female were arrested), retaliatory arrest (female was arrested), unwanted arrest, and no arrest.

Frye and colleagues (2007) found that female victims were arrested (in either dual arrests or retaliatory arrests) in 34% of the cases they studied. "It is possible that these callers are partnered with higher-income men who may have the social power and/or knowledge of the criminal justice system required to convince the responding officers that both parties should be arrested" (Frye et al., 2007, p. 403). Dual arrest can also occur in situations where neither party has influence and prior domestic incidents were on record.

Frye and colleagues (2007) found that socioeconomic factors played an important role in determining who was arrested. "Dual arrest cases were over three times as likely to be making more than $30,000 per year" (p. 401). On the other hand, cases where an arrest was necessary but not made tended to involve victims receiving public assistance. The authors concluded that women on public assistance received less than thorough investigations.

Frye and colleagues (2007) found that retaliatory arrests tended to be made when a previous incident was on record. Unwanted arrests occurred when the helpline professionals determined that the perpetrator represented a serious safety threat to the officer or others.

Once an arrest is made, no-drop policies come into effect.

IPV and Firearms

> *In 1994, the Violence Against Women Act's amendment to the Gun Control Act of 1968 made it a federal crime for a person who is subject to a qualifying order of protection to possess, ship, or receive a firearm or ammunition which has been shipped or transported in interstate or foreign commerce. (Karan & Stampalia, 2005, p. 79)*

Domestic firearms can play a particularly grim role in couples with a history of IPV: One out of every four battered women who attempt suicide use guns located in their homes (Karan & Stampalia, 2005, p. 79). The law prohibits ownership of firearms by perpetrators of IPV, who have appeared in court to present their position to the judge and who, subsequently, had a protection

order served on them. The "Lautenberg Amendment," passed in 1996, is the only federal misdemeanor law that prohibits firearm or ammunition possession (Karan & Stampalia, 2005). Under this amendment, the defendant must be represented by counsel and have a jury trial before being convicted. Persons can seek the return of their weapons when either the case is dismissed or the order of protection expires. Karen and Stampalia (2005) conclude that ownership of a firearm is not a "red flag" but should serve as one if the person is obsessive, possessive, or jealous and could go into a rage at the thought of being left by the victim.

Roles of Social Workers

Social workers fulfill numerous roles within the criminal justice system. As advocates, they can act as liaisons between the victims and the court. Advocates receive specialized training in the dynamics of domestic violence, the challenges faced by victims, court processes, and available services. They do not provide legal advice, but they can help victims navigate through the system.

Social workers may be contacted by the victim's or defendant's attorneys to provide information about their clients. Before releasing any information, social workers should check their agency and/or legal policies regarding disclosure; typically a release form must be signed by the client before information can be shared. The social worker should also first find out which side the attorney represents, the nature of the proceeding, the information requested and the reason why it is requested, and the time frame (Barsky & Gould, 2002).

Social workers who are served with a subpoena are legally required to testify in court. If they are unfamiliar with the process, they are encouraged to get professional legal advice and to become familiar with the laws regarding confidentiality, privileged information, and professional ethics (see Chapter 4 regarding court testimony and expert witness).

Social workers and law enforcement officers commonly work together with families experiencing violence, where they have different, and sometimes conflicting, roles. Social workers conduct assessments to determine the appropriate intervention with the family; whereas, police officers gather evidence for use in court (O'Dell, 2007). To enhance collaboration, social workers are advised to be familiar with the local policies, training, and attitudes held by police officers in cases of IPV. Collaboration would likely be improved if social workers and law enforcement officers worked these cases as a team.

Social workers can run **batterer intervention programs** (BIPs) which assist perpetrators in changing their attitudes and behaviors toward intimate partners. If perpetrators successfully complete the programs, they can avoid further retribution including jail, removal of firearms, and fines (see Chapter 12).

Mediation and other processes are referred to as **alternative dispute resolution** (ADR; Imbrogno & Imbrogno, 2000). Couples involved in mediation may use a mediator, rather than a judge, to agree upon a mutually satisfactory outcome in their case. **Restorative justice** (RJ) is one such type of mediation. RJ involves one or a series of conferences or meetings to "restore victims, offend-

ers, and communities through participation of a plurality of stakeholders in the process of recovering from crime" (Mills, Grauwilder, & Pezold, 2006, p. 365). In the process, a contract is developed to restore what the victim has lost (including dignity); both parties must agree on the contract; the abuser is remorseful; and the victim feels empowered (Grauwilder & Mills, 2004). Grauwilder and Mills (2004) assert that RJ is rooted in feminist values of "victim safety, victim choice, offender accountability, and system accountability (Edwards & Haslett, 2002)" (p. 64). The process may involve not only the family, but also friends and community members as a healing takes place at all system levels.

According to Katherine van Wormer (2009), the values of social work are congruent with the principles of restorative justice, including "service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2000)" (p. 113). Further, she recommends that social work reestablish its historic role in the criminal justice system and realize the benefits of RJ instead of mandatory arrests and prosecution of perpetrators. Using RJ in IPV situations has raised objection from some experts; further research is needed to understand the full impact and potential effectiveness of this approach in families experiencing IPV.

Summary

Victims of IPV can utilize orders of protection to protect themselves from offenders. There is mixed evidence about the overall effectiveness and consequences of orders of protection.

The court process can be intimidating for victims of partner violence. Social workers play a vital role in helping families maneuver through the system as they act in various roles including advocates and mediators. In their various roles, social workers must keep their clients' well-being foremost in their minds and be cognizant of their ethical responsibilities.

Domestic Violence Defies Easy Solutions

Nicole A. Jacobs and her friend Wayne Dunnavant were stabbed to death in May inside Jacobs' small apartment at the northern edge of downtown Belleville. Nearly three months later, Jay Godt was found slumped in a recliner, beaten to death with a baseball bat. Last week, four people—three adults and an infant—were killed in what police said was a rage-fueled shooting rampage inside another Belleville apartment.

The circumstances of the murders were different, but the dead are believed to have had one thing in common: They were victims of domestic violence, allegedly killed by people who knew them and in some cases were intimate with them.

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Police officers throughout St. Clair County are trained to identify the signs of domestic violence, and many police departments have advocates for victims. The county is also unique in that it has a domestic violence unit, called the Renee Center, where two sheriff's deputies and three assistant state's attorneys follow up on domestic violence reports. The circuit court in Belleville also has a coordinating council that looks specifically at how the legal system can better handle domestic violence.

But for law enforcement, particularly in Belleville—where nine of 13 murders since December have been domestic in nature—efforts to tackle domestic violence have been seemingly overwhelmed. And these murders, officials say, simply underscore the difficulties of predicting and preventing deadly violence that originates behind closed doors.

"There's very little you can do to prevent these," said Roger Richards, director of the Southwestern Illinois Law Enforcement Commission, which offers training in domestic violence response to police officers from Madison, St. Clair, Monroe and four other counties. "The irony, of course, is that this month is domestic violence awareness month."

Orders of protection are one form of defense, and so far this year 599 have been filed in St. Clair County. But law enforcement officials worry that these often don't work and sometimes have unintended consequences.

Nicole A. Jacobs, 27, had an order of protection issued against her husband, Leron O. Wilborn, of Cahokia, who has been charged with her murder. But in an interview Wednesday, just hours before the quadruple slayings in Belleville, Police Chief Terry Delaney wondered whether that order might have worked against her.

"In this particular case, it seems to have motivated the person," Delaney said. "It put him over the edge. It inflamed him into doing what he did."

Jay Godt's wife, Joanne, was charged with his murder. Neighbors said they saw her beat him regularly outside the couple's Belleville trailer.

On Wednesday, Belleville Mayor Mark W. Eckert and Delaney had just left a vigil focusing on domestic violence at Mount Carmel Chapel in Belleville when Delaney received a call about the quadruple murder.

On Friday, Jason D. Smith, 28, of Dupo, was charged with killing his ex-girlfriend, Nicole Willyard, 19; her 9-week-old baby, also called Jason Smith; her friend, Mary Cawvey, 19; and Brandon Lovell, 23. Smith allegedly was enraged that Willyard's child might have been fathered by another man. Some family members also believe he was upset because he believed Willyard was beginning a relationship with Lovell.

Smith's neighbor, Delores Blair, of Dupo, felt that someday Willyard's life might end if she continued her relationship with him. From her window, Blair saw him punching Willyard in a car outside his trailer.

"He beat her all the time," Blair said. "I figured one of these days he either was going to kill that girl or beat her really bad."

Willyard never got an order or protection against Lovell, according to St. Clair County court records.

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Mary Lou Shepherd, executive director of the Violence Prevention Center of Southwestern Illinois, said the first thing victims of battery should do is call 911 and tell a dispatcher if they are afraid for their safety. The national abuse hot-line number is 1-800-799-SAFE.

Warning signs: "When a person is in a relationship, and the other person says, 'If you leave me I'll kill myself,' or 'If you leave me I'll kill you,' or 'I can't live without you,' those are red flags," Shepherd said, stressing that many people don't take the warning signs seriously enough.

"If you can talk to those dead victims, I bet they will all say to you that that person said, 'I'll kill you if you leave.'"

Shelters are the safest places to go to, Shepherd said. If the abuser learns of that location, she said, a victim can be relocated—even out of state.

Shepherd noted that Willyard might have gone to a shelter. The most dangerous thing victims can do is go to the home of friends or relatives, where a batterer will assume they might seek shelter—and find them.

"They can be endangering their family," she said. "I just wish this young woman would have known about these options."

The Violence Prevention Center shelters an average of 1,800 to 2,000 victims a year. Last year, it received 6,300 hot-line calls and averaged 500 or 600 calls a month from victims in St. Clair, Monroe and Randolph counties.

The center plans to meet near the end of this month with members of the clergy, law enforcement officials, political leaders, medical personnel and social agencies to talk about the issue.

"We all have to get involved as a community," she said. "If you see something like that happening, you have to call and report it. We all have to stand up and help each other. That's what a community is all about."

Local law enforcement authorities say their profession has made huge strides in helping victims of battery and prosecuting the perpetrators.

"If you talk to law enforcement officers, they will tell you they're doing a lot better than they were 10 or 15 years ago," said Richards, of the Southwestern Illinois Law Enforcement Commission. "In the early years, we looked at domestic violence as a civil matter; we didn't look at is a as crime. Now we take it very seriously."

Even victims who are unwilling to confront their attackers can be helped by the legal system. In St. Clair County, for example, prosecutors are beginning to pursue "victimless" prosecutions, where a case proceeds without the cooperation of the victim, Richards said.

The Violence Prevention Center also streamlines information about perpetrators and helps review and follows up on domestic violence reports.

Still, law enforcement authorities say, battling domestic violence can often seem difficult at best and futile at worst.

"Unfortunately, domestic violence can happen anywhere," said Mayor Eckert. "You cannot predict what goes on behind the doors of peoples' home and dwellings. You can't stop that." (Gustin & Hollinshed, 2005)

—Reprinted from the October 9, 2005, issue of the *St. Louis Post-Dispatch* (MO).

Discussion Questions

1. Nicole Jacobs had an order of protection, yet she was killed. What is your opinion as to the effectiveness of orders of protection?
2. The research indicates the circumstances under which officers tend to make mandatory arrests. If the police had been called to the home of Jay and Joanne Godt during one of the beatings, who would have been arrested? What reasons do you have for this decision?
3. What, if anything, could have been done to help Nicole Willyard and her baby? Based on the research as to when the prosecuting attorney tends to file charges, what would have happened to Jason Smith, the father, if he had been arrested?

Key Terms

10-day hearing
Alternative dispute resolution
Batterer intervention programs
Evidentiary hearing
Ex parte hearing
Ex parte order of protection
Injunctions
Mandatory arrests
Mediation
No-drop policy
Petitioner
Respondent
Restorative justice
Restraining orders

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Assessment and Intervention With Victims of Intimate Partner Violence

10

Domestic Violence Survivors Move Out of Abusive Relationships and Into School

Under the thumb of an abusive husband, it's not easy to take college courses. Susan tried. But when she sat down to study, her husband would complain that she wasn't making supper. He controlled access to their car, their cell phone, the money.

A friend who had been through it herself recognized patterns of abuse and urged Susan to seek help. With support from a community center for domestic violence survivors, she moved out last year with her son and daughter.

Within a month, the center had helped her enroll at the Chelsea, Mass., campus of Bunker Hill Community College. Through a groundbreaking

(continued)

partnership between the college and HarborCOV (Communities Overcoming Violence), Susan received a grant covering tuition for one course, child care, and books. And she instantly joined a supportive network of counselors and fellow students breaking free from abusive relationships.

The need for education "is one of the significant comment issues for survivors [of abuse]," says Rita Smith, executive director of the National Coalition Against Domestic Violence . . . For Susan, moving out on her own was a huge relief—"just knowing that [my ex-husband] had no control over whether or not I got an education . . . Being able to sit down and do [homework] without anybody bothering me, it was good." (Khadaroo, 2007)

—Reprinted from the October 18, 2007, issue of *The Christian Science Monitor* (Boston, MA).

Susan's story is one of success. She escaped from her abuser, became empowered, and moved toward economic and emotional self-reliance. Among the professionals able to assist Susan were social workers, who played a key role in helping Susan find her freedom through the use of the shelter and counseling services. To work successfully with clients, social workers need to develop critical skills such as "active listening, empathic responding, and goal setting" (Harder, Cox, Grotelueschen, Simpson, & Lozier, 2007, p. 13).

These skills are used within the seven areas of the problem-solving model: "engagement, assessment, planning/contracting, intervention, evaluation, closing, and follow-up" (Harder et al., 2007, p. 14), which is taught in many bachelor of social work (BSW) programs (Kirst-Ashman & Hull, 2009). The basic steps of this model are:

- **Engagement:** In this stage, the social worker develops a professional relationship with the client, discusses expectations, offers services, and explains the process.
- **Assessment:** This stage involves the client, requires judgments, identifies client's strengths, and is an ongoing process (Harder et al., 2007; Kirst-Ashman & Hull, 2009).
- Planning/contracting: This stage involves working with the client to define the problem, prioritize needs, establish goals and objectives, and specify action steps (Harder et al., 2007).
- Implementation: This is the "doing" stage, which includes the involvement of risk management, crisis intervention, and counseling (Kirst-Ashman & Hull, 2009).
- Termination: This stage can be planned or unplanned; if planned, actions are implemented to address emotional reactions and prepare client for future independence.
- **Evaluation:** This stage is for determining the effectiveness of the intervention using program evaluation skills.
- Follow-up: This final stage involves contacting clients, after termination, to determine their level of functioning and to offer additional services if needed.

This chapter focuses on the first four stages of the problem-solving model—engagement, assessment, planning/contracting, and implementation—for working with victims of IPV. The chapter presents theories, tools, and models for empowering victims as well as safety plans, crisis counseling, and long-term intervention strategies.

Engaging the Client

Engaging clients includes apprising them of the therapist's legal responsibilities (such as mandated reporting of suspected child abuse if that should arise) as well as their rights as clients. Those rights include the clients' knowing what will occur, the anticipated length of the intervention, and how records will be kept. They also have the right to involvement in selecting goals and objectives, determining termination, and taking control over their lives. These rights are explicated in the National Association of Social Workers (2008) Code of Ethics (Standard 1.00).

Finally, consent forms are signed for gathering data and for sharing information with relevant sources such as medical and law enforcement personnel. "Confidentiality is paramount in social work practice and is reflected in the NASW Code of Ethics. . . . In order to engage and build trusting relationships with clients, [social workers] must offer confidentiality" (Harder et al., 2007, p. 24).

Clinicians need to pay special attention to clients' confidentiality in light of the federal privacy initiative known as the **Health Insurance Portability and Accountability Act** (HIPAA), in which policies regarding the privacy of personal health information (PHI) has shifted to better suit the needs of the business interests of the health care industry (Yang & Kombarakaran, 2006). Records are no longer maintained by private clinicians; instead, records become part of clients' medical file used for treatment, payment, and/or health care operations. "Not only has computerization of patient records expanded access, it has increased the potential for breaches of privacy to a level that was previously impossible, according to Rice and Katz (as cited in Yang & Kombarakaran, 2006, p. 130). Clients have the right to a clear explanation and communication about their patient record and to see and possibly object to its contents. In light of HIPAA, clinicians need to be judicious in their recordings, understand HIPAA's provisions, and take advantage of opportunities to keep updated with this and state policies as to client confidentiality. This is especially true in sensitive cases such as those involved in divorce and custody disputes (Yang & Kombarakaran, 2006) and, potentially, in cases of intimate partner violence (IPV).

Assessment Process

A comprehensive assessment helps social workers understand clients' problems, their causes, and possible solutions. This is also the time to establish a safety plan in collaboration with the client. Clients' strengths (e.g., compassion, empathy, insight, or religion; Black, 2003) should be taken into consideration, along with outside systems (e.g., day care centers and employment opportunities) that can be utilized on clients' behalf. Assessments are assisted through the

use of psychometric (measurement) tools, entrenched in steps toward victims' empowerment, and required to enable diagnoses and appropriate intervention strategies (Kirst-Ashman & Hull, 2009).

Assessment for IPV

Despite the prevalence of IPV (Tjaden & Thoennes, 2000), many clinicians fail to screen their clients for its existence (Schacht, Dimidjian, George, & Berns, 2009). McCloskey and Grigsby (2005) recommend that clinicians in mental health centers provide routine IPV assessments for all female clients within the general clinical population. They pose that such assessment is necessary because women constitute the majority of clients presenting for mental health services, IPV victims are overwhelmingly women suffering from psychological symptoms as a result of IPV victimization, misdiagnosis can result if the clinician does not identify the presence of IPV, and IPV must be recognized to enable appropriate safety planning (McCloskey & Grigsby, 2005, p. 267). The initial IPV screening consists of seven questions, which can be part of the overall assessment, can address the female's present or past intimate partner, and can be memorized by the clinician (see Exhibit 10.1). The questions address arguments that occur between the client and her intimate partner (McCloskey & Grigsby, 2005, p. 271).

For the safety of the client, clinicians are to assess their female clients privately and without the partner present (Rathus & Feindler, 2004). Written questionnaires are not to be used because female "clients tend to self-disclose painful and sometimes shameful IPV material at a greater rate during face-to-face interviews than on paper-and-pencil questionnaires (Campbell, 2000; Murphy & O'Leary, 1993)" (McCloskey & Grigsby, 2005, pp. 267–268). First and foremost in working with IPV victims is to ensure their safety (McCloskey & Grigsby, 2005). If no evidence of IPV exists, the assessment can continue as usual.

For clients who do display evidence of IPV, a full-scale IPV assessment is to be completed, which consists of three parts: (a) history taking, (b) determining the primary batterer and victim, and (c) lethality assessment (McCloskey & Grigsby, 2005). "These three areas help the clinician assess the frequency, duration, and intensity of IPV as well as possible avenues for effective intervention" (McCloskey & Grigsby, 2005, p. 268).

History taking is about IPV-related issues including incidences across time, intervention by others, and use of substances (see Exhibit 10.2).

Determining the primary batterer and victim identifies the person responsible for continuing the abuse (McCloskey & Grigsby, 2005) and is especially helpful with same-gender partners, where power imbalance is particularly difficult to determine (Renzetti, 1992). These questions are asked so that "the psychological effects of IPV can be more completely described for each client and to aid in diagnosis" (McCloskey & Grigsby, 2005, p. 268). Table 10.1 "provides conceptual factors so that the clinician may categorize client responses in a reasonable fashion" (McCloskey & Grigsby, 2005, p. 268).

Lethality assessment is imperative because the most important part of the assessment is the victim's safety (see Table 10.2; McCloskey & Grigsby, 2005). Women in particular tend to perceive inaccurately their risk of harm by their abusive partner. They may underestimate their risk, but they seldom overestimate it (Campbell, 2004). Understanding the level of lethality (amount

Exhibit 10.1

Initial IPV Screening Questions

- How do arguments usually begin?
- Why do you think these arguments keep happening?
- During your last argument, where were you? (Give as much detail as you can, such as where you were standing and where your partner was located.)
- How long did the incident last?
- How did it end?
- What happened when it was over?
- During your arguments, did you or your partner ever (be *very* specific):

  Slap
  Grab
  Punch
  Kick
  Bite
  Push
  Push to ground
  Pin to ground/wall
  Pull hair
  Hold
  Twist arm
  Hit with an object
  Break objects
  Tear clothes
  Throw food
  Punch fist through wall
  Break down door
  Strangle/choke you
  Beat up
  Use gun
  Use knife
  Use other weapons
  Force sexual activities
  Threaten to hit
  Threaten to kill
  Harm/neglect kids
  Harm/neglect pets
  Threaten kids/pets
  Threaten others
  Threaten suicide

- *If client says that none of the above violence occurred,* ask if it has *ever* occurred since the relationship started, or in past relationships.
  - *If no,* you may end the screening. Go on to the other partner and complete the next screening.
  - *If yes,* continue with full assessment.

Reprinted with permission from "The Ubiquitous Clinical Problem of Adult Intimate Partner Violence: The Need for Routine Assessment," by K. McCloskey & N. Grigsby, 2005. *Professional Psychology: Research and Practice, 30*(3), 264–275.

Exhibit 10.2

History Taking

Intimate Partner Violence Across Time

- What is the *first* incident you remember?
- What is the *worst* incident you remember?
- What happened during the most recent incident?
- Were there any injuries? If so, to whom and what kind? How were they handled?
- Were children involved in these incidents, or did they observe what happened?
- Were you (or your partner) pregnant during any of these incidents?
- Have you (or your partner) ever been stopped from getting help or accessing emergency services (locked in house, phone pulled from wall, etc.)?
- Were you afraid for your safety? Why or why not?
- Are you (or your partner) currently considering leaving the relationship? Are you currently separating?
- If your partner were here, how would he or she describe the incident(s)?

Intervention by Others

- Was there any outside intervention during the incident(s)? Did someone try to stop it (children, family, friends, neighbors, police, etc.)?
- Have the police ever been called to your home? Why?
- Were the police called after any of these instances?
- If yes, have you seen the police report? If I had the police report in front of me, what would it say?
- Have you (or your partner) ever been arrested/convicted of domestic violence? If so, where and when?
- Have you (or your partner) ever been arrested/convicted for any other criminal activity? If so, what, where, and when?
- Have you (or your partner) ever hurt someone or been violent in front of others? If so, who, where, and when?
- Have you (or your partner) ever threatened or harassed family members, friends, or coworkers? If so, who, where, and when?
- Have you (or your partner) ever obtained a protection order against the other? If so, where was it obtained, and for what?
- Have you (or your partner) ever violated a protection order or ignored the orders of a police officer, judge, or probation/parole officer? If so, where and when?
- Mental Health/Substance Abuse Issues
- Were you (or your partner) drinking or using any other drugs at the time of the incident? If so, what and how much?
- Have you (or your partner) ever received treatment for a mental health issue? If so, when was it obtained, and for what (consider obtaining release of information)?
- Have you (or your partner) ever received treatment for domestic violence? If so, when and with whom (consider obtaining release of information)?

Exhibit 10.2

History Taking (continued)

- Have you (or your partner) ever been treated for depression or past suicidal thoughts/ attempts? If so, when, where, and how (consider obtaining release of information)?
- Have you (or your partner) ever said you would kill yourself or others? If so, when, where, and how?
- Do you (or your partner) have access to weapons of any sort, or received weapons training in the past?

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of dangerousness) of the perpetrator can help social workers provide adequate safety planning, risk assessments, crisis intervention, and effective social services (Roberts, 2007). Batterers' behaviors and beliefs are at extremely high risk for lethality if the batterer (a) perceives that the relationship is threatened; (b) has threatened to kill himself or his partner or says he can't live without the partner; (c) is unemployed and feels there is nothing to lose; (d) has been violent; (e) stalks or monitors victim's behavior; and (f) uses drugs. The lethality assessment is to be updated and the safety plan reviewed on a regular basis.

Therapist knowledge of barriers in the environment is necessary to provide services to clients. Knowledge is required of the criminal justice systems' responses to IPV (e.g., criteria for police intervention and legal options for victims; McCloskey & Grigsby, 2005, p. 268). Knowledge is required of cultural and gender-based societal expectations (e.g., some persons in the client's milieu may have negative views of law enforcement that would hinder the victim's protection). "Clinicians must be able to embed and integrate standard psychological assessment and intervention strategies within the issues" as shown in Table 10.3 (McCloseky & Grigsby, 2005, p. 269).

Assessing for Co-Occurring Conditions

Keeping in mind that the clients' safety is the most important issue, complete assessment requires the clinician to take into consideration other potentially damaging problems the client is experiencing. Among common problems of IPV victims are those of posttraumatic stress disorder (PTSD), substance abuse, and sexually transmitted diseases (especially HIV/AIDS). These related conditions with IPV place a responsibility on clinicians to learn about the neurological, physiological, and biological systems of the body; to be informed as to legal and illegal substances and its effects; to know about medications and their effects; and to stay current on related research.

10.1 Conceptual Indicators in Determining the Primary Victim and Batterer

Primary Victim	
Indicator	**Exceptions**
Fear—expression of genuine fear of what partner will do next, may report long-standing pattern of living in fear of partner behavior.	Batterers may express fear if they believe it will convince others of own victimization or in presence of victim weapons.
Takes responsibility—assumes responsibility for partner's violence: e.g., "I said the wrong thing . . . I knew not to do that . . . I started the argument."	Batterers rarely take initial responsibility, although they may in later stages of treatment.
Admission of own violence—admits to own violence in self-defense or retaliation; will also admit to hitting first.	Batterers rarely admit own violent behavior in the absence of confronting evidence.
Pattern of abuse—usually report numerous violent or abusive incidents and can identity a pattern of escalation and what typically precedes the incidents.	Batterers rarely perceive a pattern unless pointed out by others; they cannot identify preceding situations.
Being threatened—reports that partner has threatened to harm others — children, pets, family members, coworkers, etc.	Batterers may identify partner statements of ending the relationship as a threat; in extremely violent situations the victim may also issue physical threats to the batterer in self-defense.
Trauma effects—reports dissociation, somatic complaints, depression, anxiety, sleep problems, hypervigilance, startle response, etc.	Batterers rarely report trauma effects unless they believe it will convince others of own victimization.
Goal of services—typical goal is to "stop the abuse" *and* keep the relationship intact; may wish to access help in getting safe or to leave the relationship.	Batterers rarely address the violence in goal-setting; usually want help to maintain same in relationship.
Patterns of injury—reported injuries are consistent with being attacked by another, black eyes, bruises on head, back, stomach, thighs, upper arms, grip/slap marks on skin, etc.	Batterers easily report injury yet usually of a defensive nature; such reports not to be used alone, since determination is accurate only by comparison to partner injury.
Strangled/choked — reports of being strangled by partner at some time in relationship are common, visible injury not apparent until a few days later (if ever), while there is the report of defensive injuries on batterer.	Batterers rarely report being strangled/choked by victims.

10.1 (continued)

Admission of arrests—victims will admit criminal history and give details, can describe socially unacceptable behaviors toward police during incident that may have led to arrest (for women, there may have been a gender bias operating at time of arrest)	Batterers rarely admit to criminal history; exceptions include justification for own violence or victim use of weapons.
Criminal investigation sounds incomplete—if applicable, arrest of a victim usually results from the lack of a full narrative, incomplete evidence, failure to interview witnesses.	Batterers may also report or show incomplete investigative reports, thus do not use alone.

Primary Batterer

Indicator	Exceptions
Calm, cool, and collected—overly calm, confident, no fear or apprehension about violent incident (or court process, if applicable).	Victims may dissociate or present with little or no emotion. Cultural barriers can also cause this.
Vague accounts and inconsistent chronologies—vague generalized accounts lacking in detail, time lines that do not hold; may say that partner "just acts crazy."	Victims may have memory impairment or be under the influence at time of incident. Cultural barriers may also result in reduced disclosure.
Denial—outright denial of violence against partner.	Victims may deny presence of violence due to fear, shame, guilt, etc.
Minimization—if confronted with evidence of own violent behavior, will minimize the impact: "I didn't do it, but if I did it was no big deal," or "I may have put my hands around partner's neck, but I didn't squeeze."	Victims rarely deny their own retaliatory or self-defensive violence.
Persuasion—try to convince clinician they are the injured party, ally with therapist, and sometimes ingratiate with "wink and nod" presentations.	Victims beginning to understand their victimization or who blame themselves may also do this.
Angry/demeaning—aggressively criticize partner, name call, refer to partner in demeaning ways.	Victims fully experiencing anger may do this, although rare.
Ownership of partner—conveys strong sense of ownership, jealousy, and/or obsession concerning partner.	Victims may feel these things, and should not be considered alone.

10.1 (continued)

Primary Batterer	
Indicator	**Exceptions**
Ownership of partner—conveys strong sense of ownership, jealousy, and/or obsession concerning partner.	Victims may feel these things, and should not be considered alone.
Revenge—focused on extra-marital affairs, child custody, money issues, may be smug/gloat over negative results of violence against partner (including criminal charges), ulterior motives common.	Victims may sometimes focus on infidelity or express fears around child custody (especially perpetrator threats to remove children).
Power and control—states power and control over partner (makes decisions, controls money, sets relationship rules and enforces those rules, etc.).	Victims may control some parts of relationship, or overreport control to feel safe or due to cultural norms (i.e., need to appear "tough").
Goals of therapy—to get partner to do what client wants but not necessarily to reduce violence, wants help in convincing partner to stay in relationship, wants to maintain "status quo" in relationship without getting into legal trouble.	Victims may also want help in keeping relationship intact, but also wants violence to stop.
Size difference inconsistent with facts—reports IPV incident inconsistent with size or that of their partner.	Never use size differential alone, especially with same-sex partners and in instances with weapon use.
Defensive injuries—scratches around arms/hands, bruised hands/feet compared to injuries of partner.	Must be compared to injuries reported from other partner; cannot be considered alone.
Criminal record or court knowledge—history of arrest/conviction and/or violating court orders, very familiar with the justice system, vague in describing criminal history while partner knows history well.	Some victims have been arrested even though acting in self-defense and thus know the court system.

10.2 Lethality Assessment

Severity of Violence

- Serious injury
- Attempts to kill (partner, children, pets, others)
- Threats to kill (partner, children, pets, others)
- Violence/threats in public
- Use of weapons
- Threats with weapons
- Sexual assault/abuse
- Repeated/escalating violence
- Strangles/chokes partner
- Sadistic/terrorist/hostage acts
- Violence during pregnancy
- Child abuse
- Violence in presence of children
- Threats to abduct child
- Property damage to intimidate and control
- Forcible entry to gain access to partner
- Pet abuse

Obsessive and/or Stalking Behaviors

- Following (to work, school, store, daycare, etc.)
- Watching (frequent drive-bys, drop-ins at work/school, etc.)
- Monitoring (checking telephone bills, caller ID, credit cards, computer log-ins, listening in on conversations, etc.)
- Enlisting others to follow/watch/monitor
- Telephone harassment (home, work, etc.)
- Requiring frequent "check-ins" when partner is away (work, school, store, etc.)
- Requiring debriefing after absence (partner must recount time spent away in great detail)
- Isolation of partner (physical, social, financial, etc.)
- Ownership — partner as property

Other Criminal Behaviors

- Assaults on others
- Threats/harassment of others (family members, friends, coworkers, neighbors, etc.)
- Previous criminal charges
- Pending criminal charges
- History of other criminal behaviors

Psychological Risk Factors

- Previous homicidal/suicidal attempts
- Homicidal threats
- Suicidal threats
- Previous mental health hospitalizations
- Severe depression
- External life stressors (job loss, death in family, etc.)
- Drug/alcohol abuse or addiction

Failure of Past Interventions

- Family members, children, friends, neighbors, coworkers have intervened but violence continues
- Numerous police calls
- Prior IPV arrests/convictions
- Ignores police/court/probation orders
- Violates protection or restraining orders
- Prior IPV treatment

Other

- Victim attempting separation from batterer
- Interference with victim access to emergency services or other help (pulling phone from wall, etc.)
- Weapons access
- Weapons training
- Any other unusual or concerning behavior reported by victim

From "The Ubiquitous Clinical Problem of Adult Intimate Partner Violence: The Need for Routine Assessment," by K. McCloskey & N. Grigsby, 2005. *Professional Psychology: Research and Practice, 30*(3), 264–275, appendix D.

10.3 Barriers in the Environment

Concrete Environmental Forces

1. Legal system and laws
   - mandatory arrest laws
   - mandatory sentencing
2. Police/court responses
   - enforcement of laws
   - enforcement of protection orders
   - diversion vs. time served
3. Medical/mental health responses
   - identifying causes of injury
   - believing battered women
   - counseling to keep marriage intact
4. Shelter availability
5. Advocacy center availability
6. Local social oppression against minorities and/or immigrants
7. Money
   - batterers' control over finances
   - woman's employment
   - permanent food and shelter for family
   - transportation
   - social and legal aid
   - knowledge of resources
8. Batterer himself
   - woman physically isolated (locked in house)
   - woman socially isolated due to batterer's influence
   - increased risk of death/extreme violence by batterer during attempts to leave
   - threats and violence against children

Family and Sociocultural Roles

1. Good woman = put yourself last
2. Good mother = never raise children without father
   - pastoral counseling to keep marriage intact
   - beliefs about women's place
3. Religious beliefs and norms
4. Family beliefs and norms
   - breaking rules of family of origin
5. Beliefs about divorce
6. Violence as normal within relationship
7. Definition of self as "victim"
8. Degree of cultural identification

Consequences of Battering Relationship

1. Brainwashing
   - results of repetitious violence and control
   - psychological warfare
2. Posttraumatic stress disorder (PTSD)
   - denial and numbing
   - terror and fear are normal states
   - exhaustion
   - low emotional resources
3. Learned helplessness
   - low self-esteem and self-worth
   - extreme self-doubt/immobilization
4. Stockholm syndrome
   - identifying with batterer
   - taking on batterer's belief system
   - prisoner-of-war psychological impact
5. Battered women's syndrome
   - personality change as result of battering
   - may present as mental health problem
   - recovery occurs after violence ends
   - most women do not enter into another violent relationship
6. Cognitive deficits/other disabilities
   - head trauma
   - other physical injuries
7. Forced/coerced illegal activities
   - prostitution
   - illicit drug use/sale
   - other criminal activity

10.3 (continued)

Intrapsychic Forces	
1. History of abuse physical and sexual abuse as child	2. Personal variables resiliency strengths and weaknesses

Posttraumatic Stress Disorder (PTSD)

PTSD "is a syndrome of intrusive reexperiencing, avoidance and emotional numbing, and hyperarousal symptoms that occurs in some individuals in the aftermath of a traumatic event" (DeJonghe, Bogat, Levendosky, & von Eye, 2008, p. 294). According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000, p. 463) "the symptoms [of PTSD] . . . are classified into three domains: Reexperiencing of the event (e.g., recurrent and intrusive thoughts, distressing dreams), avoidance and emotional numbing (e.g., avoidance of reminders of the traumatic event, restricted range of affect), and hyperarousal (e.g., sleep difficulties, exaggerated startle response)" (Stapleton, Taylor, & Asmundson, 2007, p. 91). Estimates of IPV victims who suffer from PTSD range widely, from 31% to 84% (Jones, Hughes, & Unterstaller, 2001, p. 110).

Victims' abuse commonly results in immune disorders, difficulty in sleeping, and gastrointestinal problems (DeJonghe et al., 2008, p. 294). They may show mental health impairments associated with the IPV such as depression, low self-esteem, and psychological distress (Bargai, Ben-Shakhar, & Shalev, 2007; DeJonghe et al., 2008, p. 294). Other symptoms can include hypervigiliance, numbing of their emotions, and suicidal ideation (Jones et al., 2001). Their conditions may worsen if they have experienced multiple victimizations, such as having been abused as a child or having been sexually abused (Bargai et al., 2007; DeJonghe et al., 2008; Jones et al., 2001).

"Recent research suggests that . . . PTSD results from IPV . . . [because] similar to other stressors, IPV activates the biological stress system of which the predominant component is the hypothalamic-pituitary-adrenal stress axis (HPA axis), which produces cortisol" (DeJonghe et al., 2008, p. 295). **Cortisol** is a hormone secreted by the adrenal glands that helps individuals cope with stressors. However, if the adrenal gland is activated for a prolonged period of time and cortisol levels become excessively high, damage can occur to the human system including psychological functioning, including PTSD, and an inability to cope with further stress (DeJonghe et al., 2008). The study of IPV effects on the brain and neurological functioning of the body is increasing (DeJonghe et al., 2008; Jones et al., 2001; Walker, 2009).

Women who are more prone to develop PTSD have experienced childhood abuse (Koopman et al., 2005), have been sexually abused by their intimate partners (Weaver et al., 2007), or have experienced chronic IPV (across both partners and time; Lewis et al., 2006). Pregnant women are particularly prone to PTSD because of psychosexual triggers associated with pregnancy (Courtois & Courtois, 1992).

Women who have developed resilience to the abuse have strong social systems that influence their mental health positively (Coker et al., 2002). Resilience in women is also attributed to personal characteristics, including control, commitment, goal orientation, self-esteem, adaptability, social skills, and humor (Connor, Davidson, & Lee, 2003). These areas of resilience can help clinicians in writing a treatment plan and implementing interventions with the client.

Substance Abuse

The amount of research on substance abuse by male perpetrators of IPV is "daunting" (Humphreys, Regan, River, & Thiara, 2005, p. 1304). Walker (2009) reports that female victims of IPV state that alcohol was the most common drug used by batterers and that alcohol was involved in 65% of the typical battering incidents (p. 231). Although alcohol has been widely studied, other legal and illegal drugs are used by perpetrators, such as benzodiazepines (antianxiety medication), opiates (heroin), cannabis (marijuana), and cocaine (Walker, 2009).

A relatively high rate of substance abuse is also noted in female victims of IPV. In their study of 360 women in eight substance abuse agencies, Swan, Farber, and Campbell (2001) reported that 60% disclosed being victims of IPV. Gathering data from women's substance abuse agencies, Downs, Miller, and Panek (1993) reported that 60% to 70% of the women had been victims of IPV within the previous 6 months. Swan and colleagues further reported that the women in their study were being treated for both alcohol and illegal drugs.

The most commonly cited theory, and the one that is empirically supported, as to the reasons that IPV victims have substance abuse problems posits that it is as a result of their coping with the attacks (Humphreys et al., 2005, p. 1306). Men tend to drink before the attacks, but women drink after they are over their attempt to recover from their trauma (Stringer, 1998; Zubretsky, 2002).

Despite these findings, policies and programs are scant that address the problems of the co-occurrence of IPV and substance abuse for victims of IPV (Humphreys et al., 2005). These women do not receive substance abuse services at shelters for IPV victims. If they enter substance abuse treatment centers, they still cannot escape their abusers and their violence (Humphreys et al., 2005; Walker, 2009). Even when they are safe in the substance abuse treatment center, victims do not receive the necessary trauma treatment (Walker, 2009). Programs are needed that address both trauma from the abuse as well as the victims' substance abuse. If female clients enter treatment and have both problems, the clinician must address them both in order to help the victim overcome the substance abuse problem and be kept safe from harm.

HIV/AIDS

There is an intersection between IPV and HIV/AIDS (Eby, Campbell, Sullivan, & Davidson, 1995; He, McCoy, Stevens, & Stark, 1998; Rountree, Pomeroy, & Marsiglia, 2008). Women who have been sexually and physically abused by intimate partners are more than three times as likely to report having a sexually transmitted disease (STD; Wingood, DiClemente, & Raj, 2000). This increased risk may result from the perpetrator not being willing to wear protection or from the victim's desire to please the perpetrator (Fuentes, 2008; Rountree et al., 2008).

The more abuse a victim suffers, the higher the risk for STDs and HIV (Fuentes, 2008). Clinicians must ask questions about the type of abuse a victim has suffered and thereby come to understand victims who have been sexually abused and their increased risk for contracting a deadly disease. Victims are empowered by information, knowledge, and choices (Rountree et al., 2008).

Assessment Instruments

Assessment instruments can provide valid and reliable measures of numerous aspects of a relationship, such as communication style, conflict areas, power relations, and marital stability. Generally clinicians will gather information through "interviews, qualitative assessment methods, behavioral observations, clinical rating scales, and self-report instruments" (Lavee & Avisar, 2006, p. 234). Clinicians are urged to select standardized measures that they are qualified to administer and score and that are culturally sensitive (Springer & Franklin, 2003).

Instruments commonly used in IPV include assessments to help determine the lethality (dangerousness) of the perpetrators. A wide range of assessment instruments are available for determining violence and related issues, including those published by Ammerman and Hersen (1999); Campbell (1995); Daley (1999); McCubbin, Thompson, and McCubbin (1996); and Roberts (2007).

Some specific assessment tools are as follows:

- The Conflict Tactics Scale-Revised: Contains 78 items to measure psychological, physical, and sexual abuse on partner's aggression (Straus, Hamby, Boney-McCoy, & Sugarman, 1996)
- The Psychological Maltreatment of Women Scale: Measures extreme forms of control by partner (Tolman, 1989)
- The Beck Depression Inventory (BDI): A 21-item self-report instrument to measure depressive symptoms (Beck, Steer, & Garbin, 1988)
- The Trauma History Questionnaire (THQ; Green, 1996): Evaluates "spousal physical violence, sexual abuse, threats, and the amount of lifetime exposure to other types of traumatic events including child abuse, crime, war, and loss of loved ones" (Bargai et al., 2007, p. 270)
- The Modified PTSD Scale-Self Report (MSSR-SR; Falsetti, Resnick, Resick, & Kilpatrick, 1993): Measures the frequency and severity of the 17 symptoms of PTSD
- The Rathus Assertiveness Schedule (RAS): A 30-item measure as to the ability of persons to speak on their own behalf (Hull & Hull, 1978)
- The Alcoholism Test (Denzin, 1987): A 16-item measure to determine the existence of a substance abuse problem

Planning/Contracting With the Client

Having gathered information about the client and surrounding systems, the clinician proceeds to make a plan with the client for further action steps. In making this plan, the clinician and client work closely together to prioritize problems, translate problems into needs, and specify goals and objectives (Kirst-Ashman

& Hull, 2009). In working with victims of IPV, the primary goal is assurance of their safety; thus safety plans are imperative.

Safety Plan

The **safety plan** involves actions an IPV victim can take for protection while in the relationship and/or while planning to leave the relationship. The plan should be written (and kept in a place where the perpetrator cannot find it) so that the victim can review it as needed (McCloskey & Grigsby, 2005). A copy of the plan should be shared with a good friend, family member, or other trusted person (Berlinger, 1998; McCloskey & Grigsby, 2005).

Some key points usually covered in safety plans include the following (Berlinger, 1998):

- Choosing a safe place in the house to which the victim can escape (if the victim is living with the perpetrator) if a violent situation erupts
- Organizing important documents (identification, children's birth certificates, social security cards, credit cards, checkbooks, money, keys, cell phone, driver's license, car registration, insurance papers, public assistance identification, sentimental items, and children's favorite toys) in one place so that a quick escape can be made
- Leaving extra clothes and other items with a trusted individual
- Installing a security system and adding locks (if the victim no longer lives with the perpetrator)
- Notifying the landlord and neighbors of the perpetrator (showing a picture) with a request to call the police if he threatens the victim
- Informing the boss and security personnel at work and asking staff to screen telephone calls
- Planning for children's protection (If children are in school, a protection order may be obtained to specify who may pick them up. Children, teachers, and other school personnel should be aware of this. Children can also be taught whom to contact if they feel unsafe.)
- Using a safe computer (out of the house) to avoid being tracked through their computer usage
- Printing and/or saving any threatening messages from the perpetrator, as these can be useful to law enforcement

The safety plan empowers victims by helping them take over their own lives. Various detailed safety plans are available online or at local domestic violence shelters (see, for example, Exhibit 10.3)

If the safety plan is to be realistic, it must be developed with the barriers in the environment understood and taken into consideration. The clinician must understand that the plan will not guarantee the victim's safety (McCloskey & Grigsby, 2005). Clinicians are to meet with perpetrators to build compliance and, if necessary to avert suicide or homicide, bring in outside authorities.

Other Intervention Plans

With the safety plan in place and the victim's safety assured to the point possible, clinicians and clients may wish to develop another plan that specifies the

Exhibit 10.3

Safety Planning Handouts for Clients Who Are IPV Victims

- Call police—911 (program phone with these numbers).
- Go to shelter (address and phone number).
- If currently safe, consider contacting advocacy center (address and phone number).
- If in same room with abuser and violence occurs, avoid rooms with no outside doors and those containing weapons (kitchen, bathroom, bedroom, garage).
- Change locks, code on house alarm system, garage door opener, answering machine access code, log-in on computer, etc.
- Identify 2 or 3 persons who are your main supporters and know of the situation and who can help you if a crisis occurs.
- Stay with family/friends who will keep you safe—hidden from abuser.
- Inform neighbors of the situation—ask them to call the police if they notice anything suspicious.
- Obtain protection order against abuser (civil or criminal).
- Develop safety plan with children such as: (a) stay in bedroom during argument, (b) leave house and go to friends/neighbors, (c) tell a relative, (d) call 911.
- Create a "code word" with children, friends, and neighbors so they can call for help.
- Give school/day care written instructions: (a) who can pick up children, (b) copies of custody papers or protection orders.
- Pack a "safety bag" and put in safe, accessible place during a crisis—extra cash, clothes, documents, extra set of car/house keys, bus tokens, quarters for phone calls and laundry.
- Save a little money each week and hide in a place only you know about (not in a car or a bank the abuser has access to)—open own bank account with statements mailed to a safe place.
- Important documents:

Birth certificates	Marriage/driver's licenses	Car title
School/medical records	Insurance information/forms	Bank account/savings passbooks
Welfare/immigration cards	Divorce papers	Other court documents
Social Security cards	Credit cards/ATM cards	Lease/rental agreements
House deed/mortgage papers	Keys for car/house	Keys for safety deposit boxes
Medications/prescriptions	Clothing (for self/children)	Comfort items (for self/children)
Address book (friends, etc.)		

THE MOST IMPORTANT THING IS YOUR SAFETY!
MAKE SURE YOU ARE SAFE BEFORE DOING ANYTHING ELSE.
IF YOU OR YOUR CHILDREN ARE INJURED,
MAKE SURE YOU ARE TREATED FOR YOUR INJURIES.
REHEARSE THIS SAFETY PLAN REGULARLY.
CHANGE AS NEEDED.
TRUST YOUR OWN JUDGMENT ABOUT WHAT IS SAFEST AT THIS TIME—ANYTHING
THAT WORKS TO KEEP YOU AND YOUR CHILDREN SAFE.

From "The Ubiquitous Clinical Problem of Adult Intimate Partner Violence: The Need for Routine Assessment," by K. McCloskey & N. Grigsby, 2005. *Professional Psychology: Research and Practice, 30*(3), 264–275, appendix F.

clients' goals and objectives to meet their needs (Kirst-Ashman & Hull, 2009). Clients may want to plan for locating housing, relocating to a temporary shelter, or continuing to stay with their abusive partners. Problems are restated as needs and objectives are written in behavioral terms. The objectives are prioritized, and action steps are discussed for achieving them.

Implementation and Intervention

Implementation of the intervention is based on the results of the assessment and the objectives in the plan (Kirst-Ashman & Hull, 2009). Intervention consists of effective services that enable victims to improve their lives. Effective services give clients realistic options toward achieving their goals. Even if clients return to their abusers, they have been given an opportunity to end their victimization and are a step closer to this end. The most effective intervention process offers victims support and reassurance as well as someone who is willing to listen and to be supportive (Shami, 2000).

Interventions are based on theoretical foundations. Various approaches have proved successful and necessary, depending on the victim's needs and situation. However, "there has been a dearth of classification schemas or typologies on aspects of victims of violent crimes, including battered women" (Roberts, 2002, p. 42). A brief review of some of the most common interventions for trauma and IPV is presented here.

Crisis Intervention

"The frequency of serious client crises confronting human service professionals has escalated to such proportions that crises have been referred to as an 'occupational hazard' in the professional literature" (McAdams & Keener, 2008, p. 388). One-third of mental health counselors will encounter the suicide of a client, and two-thirds will encounter clients' suicide attempts (Schwartz & Rogers, 2004). Crises involve both suicide and homicide threats, attempts, and acts. Crises can also occur when clients suffer severe psychiatric disorders (e.g., panic disorder or obsessive–compulsive disorder), which have doubled since 1985 (McAdams & Keener, 2008, p. 388). Victims of IPV can be said to experience crises throughout their lives with their perpetrators and especially during episodes of abusive acts; therefore clinicians working with IPV victims must be prepared for crises intervention (Young, Fuller, & Riley, 2008).

"The literature about **crisis intervention** is primarily concerned with reducing anxiety and posttraumatic stress symptoms through critical incident stress debriefing (CISD)" (Young, Fuller, & Riley, 2008, p. 346). CISD is a group crisis intervention designed by Mitchell (1983) and has been found effective with posttraumatic stress disorders (PTSD; Campfield & Hills, 2001); however, debate exists as to its effectiveness (Gist & Devilly, 2002). CISD has been helpful with victims of IPV when teams consist of law enforcement, social workers, and volunteers. On-scene personnel provide services such as counseling, support, and information (Young et al., 2008).

McAdams and Keener (2008) present a six-step preparation, action, recovery (PAR) framework for clinicians to improve effectiveness of clinicians in handling crises. In brief:

1. *Precrisis preparation* requires clinicians to learn and practice crisis procedures.
2. *Precrisis awareness* involves clinicians' acknowledgment of their shortcomings in preventing and resolving all crises and therefore their need for personal and professional support.
3. *In-crisis protocol* requires clinicians to first ensure the safety of the client, the clinician, and other parties at risk of harm. Clinicians must reprioritize their counseling goals and make resolution of the crisis their foremost goal. The client may need to be removed. Perhaps a contract can be made with the client to make sure that the client will not harm himself or herself. If other parties are threatened, they must be informed. The clinician should follow the preset protocol for the type of crisis that is occurring.
4. *In-crisis awareness* helps clinicians to work collaboratively with other professionals who may have to be contacted (e.g., hospital or probation officer) or who may be able to provide helpful services (e.g., police or other counselors).
5. *Post-crisis recovery* enables the client and clinician to discuss the crisis as to its antecedents, actions, and outcomes. They will address the losses resulting from the crisis. The sooner the client works through the crisis, the sooner he or she can proceed toward a healthier life.
6. *Post-crisis awareness* involves the clinician and client in assuring that the crisis is over before moving to other steps in the counseling process. Survivors of crises tend to deny, underestimate, or minimize the impact of the experience. "Without assistance from their counselor, some clients may simply not be able to recognize the presence or significance of the damage done by a crisis to their self-esteem, personal and professional relationships, and future goals" (McAdams & Keener, 2008, p. 395).

Although McAdams and Keener (2008) did not apply the PAR framework to IPV, their explanation is helpful in handling crises that arise because of abuse. Victims live in crises that increase as a result of the cycle of violence, and clinicians must be prepared to assist during critical times. Clinicians would be wise to prepare for crises following the steps provided by PAR.

Roberts (2005) conceptualized a seven-stage crisis intervention model, which is summarized as follows (Roberts, 2007):

Stage 1: Assessing lethality: Social workers determine the level of the perpetrator's lethality and thus the victim's safety. Information is gathered on the "(a) severity of the crisis, (b) the client's current emotional state, (c) immediate psychosocial and safety needs, and (d) level of client's current coping skills and resources" (Roberts, 2005, p. 88).

Stage 2: Establishing rapport and communication: Rapport and engagement of clients is achieved through active listening and empathetic communication to help victims develop trust. Because of their feelings of powerlessness, they are not rushed but are allowed to work at their own pace.

Stage 3: Identifying the major problems: Clients are helped to prioritize their problems. During this time, they are encouraged to ventilate about their past abuse.

Stage 4: Dealing with feeling and providing support: The social worker continues showing empathy and an understanding of the survivor's experience to assist in **normalizing** the situation. Victims are helped to understand that their abuse was not their fault. They need people who believe them, take them seriously, and praise them for the courage they showed in coping with the abuse. Validation and reassurance helps victims work through confusion and conflicting feelings.

Empowerment-oriented strategies are used in helping clients. These strategies require a trusting, collaborative working relationship between the social worker and the victim. Social workers need to believe in their clients' ability to change and to allow them to share their stories. Social workers' responsibilities include helping clients to restructure their thinking about self-blame, to understand the environmental pressures surrounding them, and to make choices for improving their well-being (Gunther & Jennings, 1999).

Stage 5: Exploring possible alternatives: Social workers help victims explore "situational supports"—that is, people and agencies that can help meet their needs; "coping skills," or behaviors that help them adapt to their situation; and "positive and rational thinking patterns," which can reduce their levels of anxiety (Roberts, 2005, p. 53). Social workers use a strengths perspective and are knowledgeable about community resources.

Social workers can help clients explore resources by providing empowering comments, information, and options. Some resources are family, clergy, neighbors, and other individuals with whom clients feel safe. Other resources include shelter programs; law enforcement, including the rules of mandatory arrest policies, orders of protection, and other court services; community services (e.g., transportation, day care services, or employment opportunities); and various social services offering material goods (food, clothing, and furniture). Clients are encouraged to use their internal resources, such as enthusiasm, courage, and determination in contacting resources, planning the future, and taking appropriate actions.

Stage 6: Formulating an action plan: A treatment plan is written by the social worker and the victim. Its extensiveness depends on the victim's wishes and abilities. Termination of this intervention occurs when the survivor has achieved the goals and has a feeling of autonomy and control. The survivor may then continue in a counseling relationship for an extended time.

Stage 7: Follow-up measures: To determine if survivors have moved forward with their plans, the social worker contacts them within 2 to 6 weeks of case closure to determine their physical safety, cognitive mastery, and interpersonal adjustment to a new environment. This contact lets client ventilate and enables the social worker to provide further resources if necessary.

Social workers provide continual support to survivors. Their willingness to request assistance must be met with respect, encouragement, support, availability, and praise. Whatever a client's decision and however

many times he or she may return to the abuser, by continuing to pursue professional help in seeking alternatives the client shows strength, tenacity, and ingenuity.

Roberts's crisis intervention model is only one of many that exist (see, for example, Sandoval, Scott, & Padilla, 2009). Social workers need to be knowledgeable about the model they choose, the needs of victims of domestic violence, and community resources available to meet these needs. Victims of crisis need social workers who provide reassurance, validation, empathy, guidance, and patience.

Trauma Therapy

Trauma therapy has been recommended to help victims of IPV reduce anxiety and depression and learn to control their emotional responses (Walker, 2009). Kubany, Hill, and Owens (2003) have successfully helped battered women recover from PTSD associated with their victimization, particularly from physical and sexual abuse, using **cognitive trauma therapy for battered women** (CTT-BW).

CTT-BW is derived from Mowrer's model of escape and avoidance conditioning (Mowrer, 1960). CTT-BW "includes various treatment elements from existing treatment: (a) psychoeducation about PTSD, (b) stress management. . . (c) self-monitoring of maladaptive thoughts and speech, and (d) talking about the trauma" (Kubany et al., 2003, p. 82). The approach also includes assessing and correcting dysfunctional beliefs and reducing negative self-talk. Various other modules, which focus on self-advocacy and empowerment, address issues such as strategies for improving assertiveness, identifying potential perpetrators, managing former partners, and avoiding revictimization (Kubany et al., 2003, p. 82). Within the treatment modules are psychoeducational sessions about PTSD, learned helplessness, negative self-talk, and stress management. Clients complete homework assignments on the various topics.

CTT rests on "assumptions that negatively evaluative language and survivors' distorted meaning of their roles in trauma underlie the chronicity or persistence of posttraumatic stress and depression" (Kubany et al., 2003, p. 90).

Survivor Therapy Empowerment Program (STEP)

Dr. Lenore E. A. Walker (Walker et al., 2009), explains the **Survivor Therapy Empowerment Program (STEP)**, which is an evidence-based, psychoeducational group treatment for survivors of IPV to help them understand "how the violence they have experienced has impacted their lives and what they can do about it" (p. 389). STEP is made up of 12 units intended for group work and is theoretically based on current feminist and trauma theory (p. 390). Each session has an educational section, discussion section, and skill-building section. The sessions include units on explaining domestic violence and designing a safety plan. Victims learn about distinguishing thoughts from feelings, stress management, managing anger, PTSD, and other conditions related to victimization.

Feminist Therapy

Feminist practice stresses the clinician's focus on clients' strengths, the provision of information and encouragement, collaborative work with clients, and the avoidance of labels of pathology (Bricker-Jenkins & Hooyman, 1986). Feminist practice is unique "not so much because of the particular techniques that are used but because interventions are designed using the lens through which the client constructs reality, and the helping relationship is more egalitarian in that the client also teaches the practitioner" (Black, 2003, p. 334).

Strengths-Based Approaches

The strengths perspective is an alternative to models that stress pathology (Chazin, Kaplan, & Terio, 2000). This perspective is based on various assumptions including that people can do well in managing their lives, helpers can assist people in understanding the qualities that have helped them survive their difficulties in life, and helpers believe in their clients' ability to reach their aspirations (Saleebey, 1997). In working with clients, "almost anything can be considered a strength under certain circumstances," such as personal qualities and traits (e.g., sense of humor, ability to write, and compassion) and lessons they have learned from the journey of life (Black, 2003, p. 335).

Using a feminist practice and strengths perspective, clinicians can help female victims of IPV to make positive changes in their lives (Black, 2003). Rather than hearing constant negative reinforcement, clients hear positives and strengths about their lives. They are given information on resources, empathy as to their situation, and reinforcement in their moves toward freedom (Black, 2003).

Eye-Movement Desensitization and Reprocessing (EMDR)

The assumptions, steps, and effectiveness of **eye-movement desensitization and reprocessing (EMDR)** are discussed in Chapter 6, as this therapy is also used with abused children and adult survivors of child abuse. This treatment was developed by Shapiro (1989) to treat traumatic memories and their psychological consequences (Spector & Read, 1999).

EMDR has eight stages: (1) history taking; (2) establishing the therapeutic relationship; (3) gathering assessment information; (4) using eye movements for desensitization and reprocessing (clients focus on the traumatic event until they no longer feel disturbed by it); (5) the installation phase, during which positive cognition is elicited; (6) time for client to mentally scan for remaining disturbance; (7) closure; and (8) reevaluation of progress (Spector & Read, 1999).

Based on their review of 15 studies using EMDR, Spector and Read concluded that "there is abundant evidence from controlled studies that EMDR is a therapeutically effective treatment for PTSD" (p. 171).

Exposure Therapy

Some studies suggest that **exposure therapy** can be effective in relieving battered women's PTSD symptoms (Stapleton et al., 2007). The procedure in-

volves four sessions of imaginal exposure to traumatic events. This is followed by four session of in vivo exposure to harmless but distressing trauma-related stimuli (Stapleton et al., p. 96). "During imaginal exposure, participants were asked to talk in the first person, present tense, about the traumatic event and what it meant to them . . . and also what they saw, heard, smelled, felt, and tasted." (Stapleton et al., p. 96). In vivo exposure took place in the office with the therapist.

Motivational Interviewing

Motivational interviewing (MI) is a technique that may help social workers and other clinicians change victims' behaviors from harmful to beneficial (Wahab, 2005). The principles of MI are (a) empathy, which the clinician expresses with clients; (b) discrepancy, which the clinician points out between clients' behaviors and their personal goals and values; (c) rolling with resistance, which prevents breakdown in communication by the clinician and allows participants to explore their views and avoid arguing for change; and (d) supporting self-efficacy, which enables the clients to be self-determining and to feel acceptance regardless of their decisions (Miller & Rollnick, 2002).

MI is based on the transtheoretical model of change (TTM), which was developed by Proschaska (1979). The TTM categorizes five stages of willingness to change:

1. Precontemplation (the person is not aware of the behavior or the need for behavior change)
2. Contemplation (the person begins exploring options for change)
3. Preparation (the person gathers information with intention to change)
4. Commitment (the person makes the change)
5. Maintenance (continuing the changed behavior)

This change process was revised to address the progress of victims toward a violence-free life by Dienemann, Glass, Hanson, and Lunsford (2007) during their design of the Domestic Violence Survivor Assessment (DVSA), which is a tool to measure survivors' movement during the process from victim to freedom from victimization. The five stages are as follows:

1. Committed to continuing the relationship
2. Committed but questioning the abusive relationship
3. Considers change: options available for ending the abuse
4. Breaks away or partner curtails abusiveness
5. Establishes a new life—apart or together

A social worker can use these categories to assess where a particular client is and to encourage victims as they move along this continuum. To assist in the process, MI provides a variety of tools to assess clients' motivation, confidence, and readiness for change. There is some initial evidence that its basic tenets hold promise for victims of IPV (see, for example, Murphy & Maiuro, 2009).

Other Approaches

Other approaches are available for helping victims of IPV recover from PTSD, anxieties, and negative feelings resulting from their abusive experience, such as self-defense classes, body therapy techniques, and relaxation (Walker, 1984). More controversial are treatments such as family and couples therapy, which are advocated by some clinicians but strongly opposed by others, including Walker (2009).

Assessments and intervention for clients' problems and needs tend to be "siloed," meaning that each is approached individually, rather than holistically, depending on the clinician's expertise (Humphreys et al., 2005, p. 1315). Further, various client needs may be treated by different agencies or service providers (substance abuse treatment facility, mental health agency, and/or medical care providers). At the very least, social workers need to be aware of the possibility of multiple co-occurring conditions in cases of IPV and the varying assessment and treatment options for each.

Intervention With Couples

According to Holtzworth-Munroe and colleagues and O'Leary, Vivian, and Malone (as cited in Schacht et al., 2009, p. 47), "[Domestic] violence is particularly common among couples seeking couple therapy, with estimates of half to two-thirds of couples seeking treatment reporting some incident of aggression in the previous year."

When domestic violence is suspected, clinicians must arrange to see the two individuals separately. This must be accomplished diplomatically, because splitting a couple may raise suspicion on the perpetrator's part, place fear into the victim, and deny the therapist the opportunity to observe the couple's interaction. Usually, one or two visits can be arranged without raising anxiety with either individual.

During individual sessions, the social worker should try to obtain a detailed account of any verbal or physical arguments, including a description of the episode working chronologically from the beginning of the time of tension to the point of the explosion. Other useful information would include third-party involvement, impact on children, consequences of the violence, the frequency and severity of the abuse, existence of weapons in the house, presence of substance abuse, history of physical injury, and the perpetrator's jealousy, dependency, possessiveness, and outside violence. These explanations assist in identifying recurring themes of each partner's emotional strengths, reciprocal needs, and defenses.

In approaching victims in private discussions, clinicians should be selective in their words and questions. The words *violence* and *domestic violence* should be avoided, as they are threatening and vague. These discussions must occur in a place where victims feel safe and are able to trust the therapist.

As mentioned earlier, there is controversy over the use of couples therapy when IPV is involved because the possibility exists that it can be dangerous (Bograd & Mederos, 1999). Bograd & Mederos suggest that couples therapy may be appropriate in cases of minor physical and/or psychological abuse. However, they suggest that it is possible only if the abuser accepts participation

voluntarily and if special issues of confidentiality are considered. Victims may be used to keeping the IPV secret for their own self-preservation; however, secrecy is nonproductive for the therapeutic process. The victim must feel able to discuss abusive acts. Further stipulations are that the abuser must admit to his role, no risk factors for lethality are evident, and a commitment is made to discontinue any violent acts.

The controversy continues over the ethics, safety, and effectiveness of couples therapy (van Wormer, 2009), rather than individual or group therapy (Walker, 2009), in issues of IPV (Bograd & Mederos, 1999). Clinicians can find research to support either side of the controversy; however, clinicians are to be cognizant that they are responsible, first and foremost, to protect their clients from harm.

Group Counseling

Victims of IPV may find sharing their experiences with other victims in a group setting helpful. By listening, being heard, and receiving support, they may find a sense of themselves separate from their abusers. In time, they can build their self-confidence, improve communication, move out from isolation, consider alternative actions, believe in their ability to have a better life, and ultimately take action for improving their lives.

Case Management

Finally, case management services provide information to victims about available services (for example, local shelters, victim assistance programs) and assist them in accessing these services for themselves and their children. Services include emergency housing, legal information, job counseling, and childcare (McCaw et al., 2002).

Social Workers' Professional Use of Self

Working with families experiencing violence can be traumatic to social workers; thus they need specialized training and supervision. **Vicarious traumatization** (VT; Iliffe, 2000) occurs when clinicians are traumatized by repeatedly hearing clients' trauma stories (Dane, 2002). Clinicians experiencing VT may display similar symptoms as their clients, including physical and mental disturbances approaching those of PTSD. Social workers may also experience burnout and countertransference (i.e., the worker's displacement of emotion onto the client), which can hinder their effectiveness (Dane, 2002).

Social workers and other professionals who work with traumatized clients are wise to be sensitized to their potential for VT, burnout, and countertransference (Iliffe, 2000; Strawderman, Rosen, & Coleman, 1997). Being aware of their potential for these reactions may help social workers avoid them. Coping strategies include common self-care techniques such as taking time for oneself, discussing the experiences with other colleagues or advisors, and engaging in regular physical activity (Dane, 2002).

Unfortunately, some social workers find difficulty in accepting assistance for their own emotional health. Wisdom comes with the experience of sharing with peers, supervisors, and their own counselors, the truth of their experiences and their emotions. Emotions and thoughts need to be constructively internalized if workers are to continue work with trauma victims. Social workers should not be "wounded healers" (Jung, 1951) who suffer from the same problems as their clients; they should first treat themselves.

Summary

According to the **change model**, social workers follow seven phases when working with their clients: engagement, assessment, planning/contracting, intervention, evaluation, closing, and follow-up. This model provides a useful framework when working with victims of IPV.

A thorough assessment enables social workers to implement appropriate interventions. The assessment for victims of domestic violence must include the risk for lethality. Victims' safety is imperative and can be assisted with the development of a safety plan.

Many interventions exist for victims of IPV. Interventions that are based on the strengths perspective emphasize the need to empower victims and enabling them to change their behaviors.

During all these phases, social workers require proper training, supervision, and evaluation to assure delivery of the most effective services to their clients.

Shotgun Removes Fingers

Larissa Camp doesn't try to hide the hand that's missing four fingers from a shotgun blast nearly four years ago. She holds her right hand up to pray, uses it to pass out pamphlets and isn't afraid to show people the result of a violent fight with a former boyfriend.

"I have a lot to be thankful for," Camp said. "I should have been dead and gone."

To Camp, a student at Moberly Area Community College, the hand is a constant reminder of the physical toll domestic violence sometimes has on its victims.

Camp, 27, of Columbia, spoke yesterday to about a dozen people at Urban Empowerment . . . as part of National Crime Victims' Rights Week, which ended yesterday. She told the group of mostly women she first met Bernard Westfall, then a 41-year-old truck driver, in July 2003.

One of the tires on her car had blown out en route to a family reunion, and Westfall stopped on the roadside to help. He asked Camp, then 23, out on a date and gave her his card. The relationship quickly blossomed, and within a few months, the couple moved in together.

(continued)

Camp said she soon realized there were problems with her new boyfriend. "No matter what I said or what I did, he was going to flip out," she said.

The verbal threats soon turned into pushing and hitting. Camp left Westfall but returned after he promised to change. The promised changes didn't last, she said. Westfall continued to hit her, and on Valentine's Day 2004 he threatened to sexually assault her.

She moved out, filed for a court's protective order in May 2004 and changed her phone number. But Westfall persisted, telling Camp's family he had found religion.

It was about that time, on Aug. 2, 2004, that Westfall asked Camp to stop by his home in the St. Louis suburb of Maryland Heights. He needed help, he told her. Please come take me to the doctor, he said.

When Camp arrived, Westfall "didn't look like someone who was sick and ready to go to the hospital," she recalled.

Westfall sat on a couch, smoking cigarette after cigarette. He asked Camp to move back in with him. She refused, she said.

That's when Westfall pulled a shotgun from a closet. Moments later, he pulled a shotgun shell from his pants pocket, loaded the weapon and pointed it at Camp's head.

"I honestly didn't know what to do," she said. "He had threatened me so many times before, I'm not sure I believed him."

Camp struggled to move the weapon away from her head. Her fingers wrapped around the barrel, and the gun went off. "There was blood all over the walls, and I looked down and my fingers were crumpled on the floor," she said.

In shock and quickly losing blood, Camp shoved her bloodied hand into Westfall's face. "I wanted him to taste what he had done to me," she said. As she ran, their fighting continued. Camp reached the front door, but Westfall stopped her and pointed the shotgun at her back. "I thought that this was it," she said.

Before he could fire, Camp wedged herself between the wall and door frame. The shotgun blast penetrated the wall and sprayed her shoulder with pellets but missed vital organs. Camp fled to a nearby home, knocking on doors for help.

She looked over her shoulder to see whether Westfall was following. "Then I heard the gunshot go off in the distance, and I felt relieved because I realized that it was over," she said.

Maryland Heights police surrounded the home and called in a tactical unit. Officers tried to call Westfall several times. After a few hours, police went inside and found Westfall dead from a self-inflicted shotgun wound.

Camp, who is originally from Columbia, moved back in February and is now studying psychology while taking care of her 1-year-old son. She hopes to become a counselor to help others overcome personal problems. (Kravitz, 2008)

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Discussion Questions

1. If Larissa Camp and Bernard Westfall had come to you, as a therapist, for help, what would you have done to help them?
2. If Larissa had come alone for help, what would you have done to help her?
3. If you were the therapist of Larissa and Westfall and Larissa again came to you after Westfall's death, how would you apply the "professional use of self" in working with her?

Key Terms

Assessment
Assessment instruments
Change model
Cognitive trauma therapy for battered women
Cortisol
Crisis intervention
Engagement
Evaluation
Exposure therapy
Eye-Movement Desensitization and Reprocessing (EMDR)
Feminist theory
Health Insurance Portability and Accountability Act (HIPAA)
Lethality assessment
Motivational interviewing
Normalizing
Safety plan
Survivor Therapy Empowerment Program (STEP)
Trauma therapy
Vicarious traumatization

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Child Witnesses of Intimate Partner Violence

11

"Elvis" Gets 15 Years for Holding Hostages

An Elvis Presley impersonator who kept his ex-girlfriend at gunpoint for hours in his Soulard home in 2004 was sentenced Friday to 15 years in prison.

At one point Gary L. Randolph, 53, held a shotgun in one hand and his toddler son in the other as he crooned his own desperate lyrics to an Elvis song on a karaoke machine, Assistant Circuit Attorney Jillian Carey said.

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Randolph has performed an Elvis act at wedding receptions and bars. Carey said he was well-known in Soulard and had a reputation as a nice guy. But she added, "People are prosecuted for what they're capable of in their darkest moments."

He had been up since about 5 A.M. waiting for his estranged girlfriend to arrive with their son, Carey said. When she got to his home in the 1200 block of Sidney Street, he asked her if there was any chance for reconciliation, the prosecutor said.

She told him only if he got counseling.

"That's all I need to know," he said before pulling out a 12-gauge shotgun and an SKS assault rifle, Carey said.

Randolph threatened to kill himself and their child, but said he would leave the girlfriend alive to suffer, Carey said. He also had his ex-girlfriend read song lyrics and poems he had written about his suicidal thoughts and sadness over the relationship, Carey said.

The woman was able to smuggle a cell phone into the bathroom and call police, who rescued her.

A jury convicted Randolph in September of kidnapping, child endangerment, domestic assault, unlawful use of a weapon and armed criminal action, and recommended 20 years in prison.

In the sentencing phase of the trial, Randolph's ex-wife testified that during their relationship, she was beaten and shot, Carey said. She also testified that Randolph had poured lighter fluid over her and stood by with a lighter. She left the marriage for a domestic violence shelter, then fled to Georgia and changed her name. (Patrick, 2005)

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Children who witness domestic violence are twice victimized: they are victims of child abuse and also of intimate partner violence (IPV). Even if they are not physically abused by the perpetrator, they suffer physical and emotional endangerment by witnessing disputes between adults. Child witnesses, of all ages suffer—even before they are born. As children hear and see the violence within their homes, they learn to solve problems by being aggressive, which results in the continuation of violence within and outside their families. This chapter examines the particular issues related to child witnesses of IPV.

Child Abuse and IPV

Over the last two decades increasing attention has been directed toward children who witness partner violence in realization of the co-occurrence between domestic violence and child abuse and in the recognition as to the adverse effects on child witnesses' physical, emotional, and cognitive development (Edel-

son, Mbilinyi, Beeman, & Hagemeister, 2003). Because most family violence research initially focused on female victims of male perpetrators, children who witnessed violence were called "the silent, hidden, forgotten, and unintended victims" (Edelson, 1999). However, much new research is now paying attention to these young victims and their need for intervention.

Typically, "children witnessing domestic violence" were defined as those who were "**eyewitnesses**" of the abuse; however, the definition is expanding to include children who hear the violence (e.g., yelling and other forms of non-physical violence). In other cases, children may be victimized when perpetrators use them as weapons: either by threatening the victim that the children will be taken away if the abuse is reported or even holding children hostage (Edelson, 1999). The definition, studies, effects, and any other considerations of child witnesses need to include these non-eyewitnesses of the violence (Smith, O'Connor, & Berthelsen, 1996).

The number of children witnessing partner violence has been estimated at 3.3 million (Straus, 1992). This is a conservative estimate because it was based only on children under 3 years of age who were eyewitnesses to physical violence. A later study estimated that one-third of all children witness some form of domestic violence (Edelson, 1999).

Of families referred for either child abuse or domestic violence, approximately 30% to 60% are experience both types of violence in their families. Between 35.2% and 70% of male perpetrators of domestic violence also abuse their children (Edelson, 1999; Smith et al., 1996). Typically, the more severe the partner abuse, the more severe the child abuse.

Sufficient empirical evidence exists as to the effects on child witnesses for legislators to consider child witnessing as a major social problem and a form of child abuse (Edelson et al., 2003).

The Impact on Child Witnesses

The impact on child witnesses involves the type and intensity of their responses to the violence (e.g., withdrawing, yelling, or becoming physically involved; Edelson, et al., 2003). The cognitive, emotional, and behavioral impact on children resulting from their witnessing domestic violence is influenced by various factors such as (a) the children's age, gender, race, ethnicity, and biological relationship to the perpetrator; (b) the mother's education, employment, living conditions, marital status, and stress level; and (c) the frequency and intensity of the abuse (Edelson et al., 2003).

Witnessing domestic violence will affect children regardless of their age, from the prenatal period to the time they become adults. Specific impacts by age are discussed later in this chapter.

"Gender differences in children's adjustment are frequently noted . . . but do not appear consistently for the same type of adjustment difficulty" (Onyskiw, 2003, p. 31). Studies differ as to which gender has most disturbances (Kolbo, 1996; Onyskiw & Hayduk, 2001). Girls tend to exhibit internalized problems (e.g., anxiety and depression), whereas boys tend to exhibit **externalized (behavioral) problems,** including aggressive acts toward the perpetrators (Kolbo, 1996).

The relationship between the children and the perpetrator influences the extent to which children tend to intervene in an abusive episode between their mother and the perpetrator (Edelson et al., 2003). Children who are biologically related to both the mother and the father are at lower risk for intervening than children who are related only to the mother. "Children and abusive men may both have more of an investment in maintaining their relationships when there is a longer term tie to each other" (Edelson et al., 2003, p. 29).

The impact on child witnesses is influenced by the mother when the mother is the victim. The impact increases for those living alone with their mothers, especially for older, adolescent children; however, it decreases for children if their mothers are married, educated, and/or employed and if the mothers have stable housing (Edelson et al., 2003). Stressors on the mother influence the impact on the children. As their mothers experience increased stress, a higher number of negative life events, and higher frequency of violence from the perpetrator, the children exhibit an increase in behavior problems and a decrease in social competence (Onyskiw, 2003).

The impact of witnessing abuse is intensified as the frequency and severity of the abuse increases. The impact is compounded when the children become the direct victims of abuse by the perpetrator. Adding to the adverse influences of witnessing violence in the home is the nature, extent, and types of violence children experience in their community and view on the media. The violence at all systems levels can either alleviate or aggravate the impact on children (Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000).

The total impact on children witnessing domestic violence is not a cause-and-effect issue. Rather, the short- and long-term consequences are influenced by their demographics, their mother's characteristics, the intensity of the abuse, and a variety of other mitigating factors such as significant persons in their lives (Edelson et al., 2003). Although children's reactions to witnessing vary, certain types of problems can be anticipated depending on the children's age at the time of the abuse. While being aware of some typical reactions, professionals need to assess and provide treatment modalities to each child as an individual rather than strictly according to their age or any other one factor.

The *Children Living in Violent Homes* wheel gives a snapshot of various problems experienced by child witnesses to IPV (*Children Coping with Family Violence*, n.d.; see Figure 11.1).

Impact by Children's Age

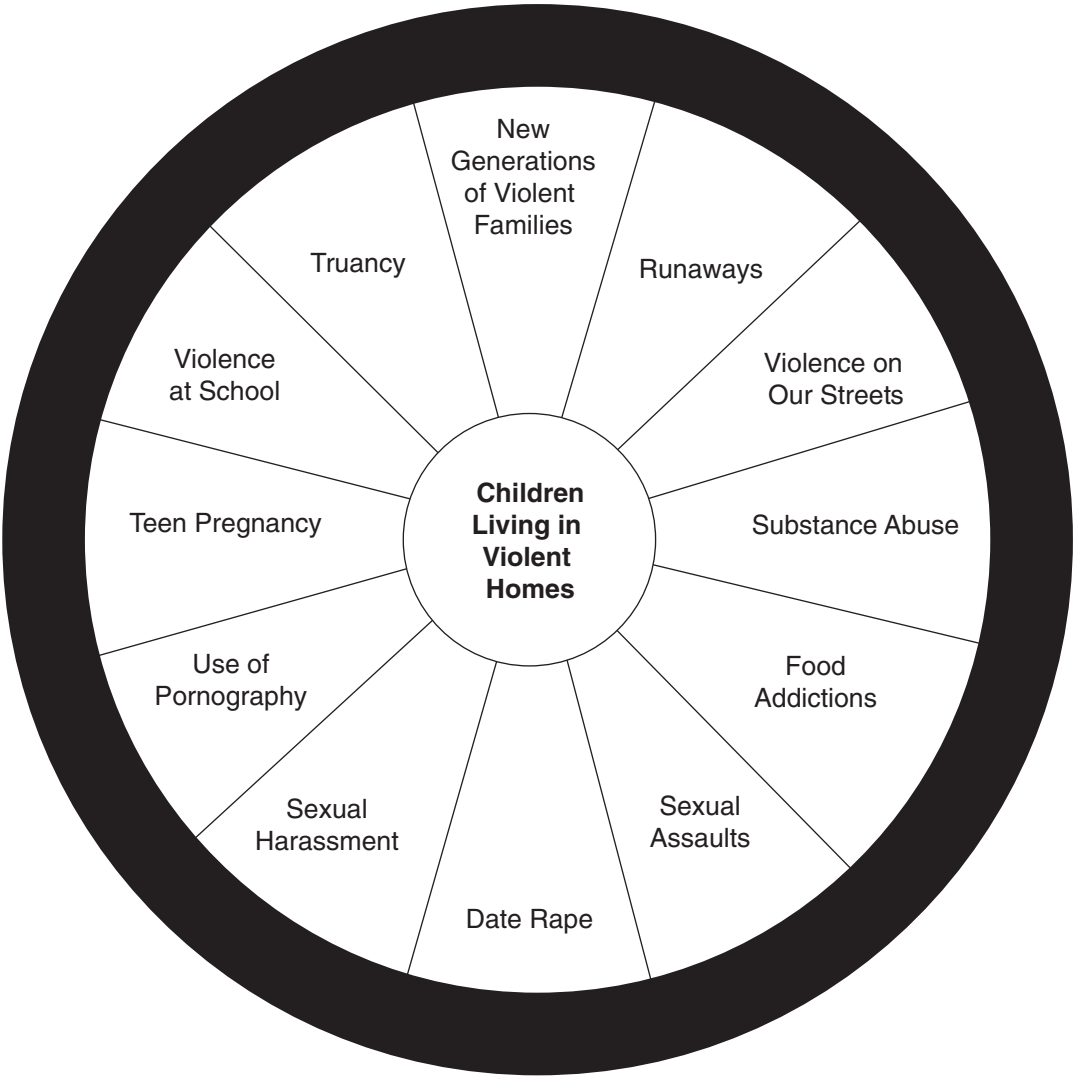
Infants

Within various studies of women being screened for IPV, an estimated 7% to 17% admitted to abuse during pregnancy (Jeanjot, Barlow, & Rozenberg, 2008; Jones & Horan, 1997; Norton, Peipert, Ziegler, Lima, & Hume, 1995). IPV can cause stress to a fetus, which can be measured by the heart rate and galvanic skin responses. "Abuse during pregnancy may have direct and indirect effects . . . [including] fetal–maternal shock and death" (Jeanjot et al., 2008, p. 564).

According to Erikson's (1963) development stages, children develop basic trust and autonomy from birth to 3 years of age. They depend on their mothers

11.1

Children coping with family violence.



to provide the basic needs of life, including security and solace. Instead, if new mothers are struggling with their own physical, emotional, and physiological needs while experiencing domestic violence, they are hampered in their ability to provide the attention and patience that are so vital to infants during this stage of life. The results may be infants' failure to thrive, "prolonged crying, irritability, difficulty sleeping, and disruption in eating and play/exploration" (Sudermann & Jaffee, 1999, p. 347).

Preschoolers

By the time children become preschoolers, they are increasingly aware of the domestic violence within their homes and, while continuing with the problems developed during infancy, they may begin manifesting an increase in negative reactions. Often, children of this age behave aggressively and may attempt to intervene during the violent incidences (Edelson et al., 2003). Children may experience problems with *enuresis* (bed-wetting) and exhibit inappropriate social behaviors with both adults and peers (Wolak & Finkelhor, 1998). At this stage they may begin to blame themselves for the violence (Smith et al., 1996).

School-Age Children

Young children may continue to blame themselves for the violence and manifest more intense behavioral, emotional, cognitive, social, and physical reactions as they deal with the additional pressures of school. They may increase their aggressive behaviors; withdraw with anxiety, depression, and low self-esteem; perform poorly academically; interact inappropriately, thus, being rejected by their peers; and suffer sleeplessness, eating disorders, and psychosomatic symptoms (Wolak & Finkelhor, 1998). As compared with children not witnessing domestic violence, child witnesses are twice as likely to be admitted to a hospital and are twice as often absent from school for health problems (Edelson et al., 2003). These children grow up confused about the meaning of love, violence, and intimacy (Wolak & Finkelhor, 1998).

Adolescents

Adolescent witnesses exhibit higher rates of delinquency, assault, running away, drug and alcohol abuse, and suicide than other adolescents (Wolak & Finkelhor, 1998). **Internalized symptoms** may be manifested through depression and low self-esteem (Onyskiw, 2003). "Straus, Gelles, and Steinmetz (1980) also reported that boys who witness paternal violence are at a 1,000% increased risk for assaulting their own partners as adults" (as cited in Pelcovitz et al., 2000, p. 366). Adolescent boys may intervene in the violent episodes between their mothers and male perpetrators.

Throughout their development, youth witnesses may show signs of post-traumatic stress disorder (PTSD; Lehmann, 2000). These youth experience headaches, nightmares, shakiness, feelings of numbness, inability to remember important aspects of events, and exaggerated startle responses (Lundy & Grossman, 2005). As PTSD is not uncommon for child witnesses, professionals need to conduct a thorough assessment for determining its presence and for providing an appropriate intervention (Lehman, 2000).

Social Workers in Child Abuse and Partner Violence Systems

Social workers have critical positions for dealing with co-occurring child abuse and domestic violence situations; however, they have come under criticism for

failing to identify and intervene with these families (Humphreys, 1999; Johnson & Sullivan, 2008). At times, strategies to help female victims of partner violence have resulted in further victimizing them. Social workers have informed mothers about the impact of domestic violence on their children, thinking that the mothers would be motivated to leave for their children's sake. Instead, these women have felt guilty—as if they were being blamed for exposing their children to the violence (Johnson & Sullivan, 2008).

Workers in domestic violence shelters have been criticized for overlooking the children's needs in coping with the trauma in their lives (Johnson & Sullivan, 2008). When abused women leave their abusers and seek protection within shelters, they place themselves and their children in a safe but still traumatic situation. These women depend on social workers within the shelters to help them with the many decisions and actions needed to obtain a healthy family lifestyle. Shelter workers provide assessments and interventions for female victims; they need to provide the entire family with services (Humphreys, 1999; Stanley, 1997).

Despite some criticism, many social workers empower victims of domestic violence by educating them and providing services to assist them and their children (Johnson & Sullivan, 2008). They can be supportive and often advocate on the mothers' behalf. They have held male perpetrators accountable for their abuse. With increased training and resources, workers can enhance these positive aspects of their interventions (Coohey, 2007).

The social service system that protects victims of child abuse and partner abuse depends upon coordination and collaboration among professionals. Training is one essential component to achieve this goal. Child Protective Services (CPS) workers need to increase their knowledge about domestic violence so they can identify its existence and provide intervention for all family members. Likewise, social workers employed in shelter programs for domestic violence victims and in treatment programs for perpetrators require increased sensitivity to the adverse impact to children (Humphreys, 1999; Stanley, 1997).

Assessment of Child Witnesses

A dangerous myth about IPV is its nonexistence in middle to upper socioeconomic families (Weitzman, 2000). IPV has no boundaries—economic, spiritual, racial, or educational. Dispelling this myth encourages social workers to assess all families for domestic violence using prediction models and assessment instruments.

If domestic violence is suspected, a **system of safety** is to be established, which is a safety plan to assure children protection inside and outside their homes (Cooley & Frazer, 2006, p. 462). Included in the safety plan are means of escaping future episodes of violence by knowing safe places to hide, people who can be called for help, and other resources. These steps should be role-played with the children in preparation of future episodes. Prevention of further exposure to witnessing domestic violence is crucial in minimizing any further harm (Wolack & Finkelhor, 1998).

Safety assessments require lethality assessments of the adults to determine the extent of the danger to which children have been exposed and the advisability of the children being with one or both adults. Lethality is increased with

perpetrators' chronic alcohol abuse, severe violence within the home, and violent episodes outside of the family (Saunders, 1995).

The assessment should include interaction with children to observe subtle symptoms including attitudes about conflict resolution as well as knowledge and skills in dealing with violent incidents; children who have witnessed domestic violence are often lacking in these areas (Allen, Wolf, Bybee, & Sullivan, 2003; Tutty & Wagar, 1994). Other symptoms to assess include the children's demonstrating either the need to protect their mothers against their perpetrator or their demonstration of abusive verbal behavior toward the mothers as they mimic the perpetrator (Allen et al., 2003).

All children in the home need an assessment for intrapersonal and interpersonal problems. Observing and talking with siblings is essential. Siblings living in violent homes vacillate between protection of and violence toward one another (Edelson, 1999; Hurley & Jaffe, 1990). Their problem-solving skills most often involve the use of violent acts. Because these children tend to be jealous of one another, these violent acts are frequent (Hurley & Jaffe, 1990).

The assessment requires a **multimethod approach** (O'Leary & Murphy, 1999). Areas for further investigation are disclosed by observing the children's symptoms, interactions among the children, and interactions between the children and adults. Data are to be gathered from the children and from the adults about cognitive, emotional, physical, and spiritual aspects of their lives. Some techniques for assessing data are **ecomaps,** which diagram the family's current connections with the environment, and **genograms,** which identify intrafamilial patterns over time (Paquin & Bushorn, 1993). The assessment combines observations, verbal information from all parties, and data from any other sources (past records and other individuals).

Intervention With Child Witnesses

The assessment of child witnesses dictates whether intervention is necessary and if it is, the type of intervention to pursue. This also depends upon the children's placement (e.g., whether they are in shelters) and their alternative supportive resources (e.g., grandparents). There is no one way of treating these children (Allen et al., 2003; Friedrich, 1996).

Working with children begins with building rapport. Cognitive, physical, and social problems are verbally revealed by the children when they are ready. The existence and extent of these problems will be revealed as the trust increases between the children and the social worker.

Preschool children witnessing domestic violence often require social distance to prevent exacerbating their anxiety (Alessi & Hearn, 1998). The impact on children can be alleviated using human and animal doll families, aggressive human and animal doll figures, human and animal puppets, drawing materials, telephones, and tactile materials (Alessi & Hearn, 1998).

During the abuse-focused aspect of treatment, children are to be assisted in exploring various aspects of their trauma. The process includes identifying people and places in which the children feel safe, revealing the secrets that the children promised to keep in relation to the existence of the abuse, and exhibit-

ing the extent of damage to their psychosocial development. This is a difficult and often long-term phase but is essential for children's treatment (Karp & Butler, 1996).

Ongoing strategies for assisting these children require repairing children's sense of self, processing feelings of guilt and shame associated with the trauma, and learning new, appropriate coping skills. The final stages move the children into becoming future-oriented and empowered over the paths their lives will take. These processes require therapists experienced in working with children to prevent unhealthy transference and countertransference between the children and their therapists (Karp & Butler, 1996).

For children in protective shelters, group therapy is effective in alleviating the trauma of having witnessed domestic violence (Alessi & Hearn, 1998). Crisis and short-term intervention is most feasible considering the lack of stability within the family (Alessi & Hearn, 1998; Mullender, Debbonaire, Hague, Kelly, & Malos, 1998). Even six sessions can help children identify feelings, improve problem-solving skills, and learn healthy interpretation of love and intimate relationships. When possible, group work should accompany individual counseling (Alessi & Hearn, 1998; Mullender et al., 1998).

The elimination of problems resulting from children witnessing domestic violence accompanies the abeyance of the violence within the home and implementation of a multidisciplinary, communitywide approach (Witwer & Crawford, 1995). This approach includes identifying, pursuing, and obtaining long-term funding for interventions; having specialists and advocates in all practice settings; and maintaining comprehensive management information systems. The coordinated effort requires commitment from the criminal justice system, social workers, school personnel, domestic violence program staff, media, businesses, and all community citizens interested in stopping family violence.

Summary

Witnessing IPV is emotionally and psychologically damaging to children, and the consequences can last well into adulthood. Often the systems that protect children and adult victims of family violence lack the resources to maintain a coordinated effort toward returning families to healthy sanctuaries. Reducing partner violence and the problems experienced by children who witness this violence requires the committed effort of social workers and other professionals.

Recommendations for furthering the efforts toward achieving this goal are as follows: (a) form communitywide task forces for a coordinated effort toward education, prevention, and intervention of family violence; (b) coordinate the services of social workers in CPS and in domestic violence shelters; (c) take a holistic approach when working with families; (d) conduct research and evaluation to determine the incidence rates of children exposed to domestic violence, the effects on these children, and effective intervention approaches to help them and their families; (e) implement programs and policies based on the results of the research; (f) include "child witnesses of domestic violence" in the definition of child abuse and in the statutes for protecting children; and (g) include theories, assessment techniques, and intervention strategies within the social work curriculum.

Remembering Crystal

Last week marked two important dates for Lane Judson. Thursday, April 24, was his daughter Crystal's birthday. But rather than celebrating the day, Lane and his wife, Patty, were reminded of another event—the five-year anniversary of one the biggest crimes in Gig Harbor history.

In 2003, just two days after their daughter turned 35, Crystal Judson Brame was killed by her husband, David Brame—who, at the time, was the Tacoma Police Chief.

Brame shot his wife in the parking lot of a Gig Harbor shopping center before turning the gun on himself. The Brames' two children, Haley and David Jr., then 8 and 5, respectively, were witnesses.

In the days and months that followed, shocking revelations about Brame became public: He was prone to domestic violence, having abused Crystal for nearly a decade before their divorce, and he had used his power as police chief to intimidate Crystal and prevent her from reporting his abuse.

But the following months also marked legal and personal accomplishments on the part of Crystal's father.

Lane Judson began campaigning for state and federal reform of domestic violence laws. He filed a lawsuit against the Tacoma Police Department for wrongful death. And he has provided seminars on domestic violence prevention to police departments across the country.

Time has also allowed the Gig Harbor community to heal. The Crystal Judson Foundation, a non-profit organization that sponsors events and promotes education to prevent domestic abuse and violence, has also been formed.

Lane Judson said that the many opportunities he's had to speak about his daughter's life allowed something good to come from a tragedy—namely that others, like Branscom, may help prevent domestic violence from happening.

One of the biggest steps Lane Judson took in the past five years was advocating for the Crystal Judson Brame Domestic Violence Protocol Program, a federal law that provides grant funding to law enforcement agencies to educate their officers about domestic violence. Both Lane and Patty Judson felt that their son-in-law's position in the police department was what allowed his abuse against his daughter to go unpunished.

Reports disclosed after Brame's death, for example, revealed that he had failed two of three necessary psychological examinations for employment in law enforcement.

"If you work down at McDonald's . . . and you do domestic violence, I can't do anything about it," Lane Judson explained. "But if you're a public servant, and you took an oath to uphold the law to protect—and even to protect the ones that you love—and you violate . . . that law, we don't need you as a police officer."

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At the same time Lane Judson was campaigning for federal change, other changes were happening locally. The state of Washington passed the Crystal Clear Initiative in 2004, a law that mandates that every state law enforcement program has an officer-involved domestic policy in place.

The Judsons also filed a wrongful death suit against the City of Tacoma, claiming that the city should never had hired Brame in the first place and that the department needed to be reformed. The lawsuit was settled out of court in 2006, with $12 million awarded to Haley and David Jr. as the sole beneficiaries.

The Brames' children, who are now under the legal guardianship of Crystal's sister and brother-in-law, Julie and David Ahrens, are doing well, Patty Judson said.

Lane Judson added that it's difficult to consider their grandchildren's lives normal when they have "experienced such a tragedy" of losing their mother and father, but that he and his wife attempt to keep Crystal's memory and name alive for Haley and David Jr. . . . the Crystal Judson Family Justice Center was formed in late 2005. (Richmond, 2008)

—Reprinted with permission from the *Peninsula Gateway*.

Discussion Questions

1. As a social worker for the two Brame children, what would you anticipate the impact to be on them, taking into consideration their age at the time of abuse, their demographics, mother's characteristics, and severity of the abuse? How would you access for these symptoms?
2. What is your opinion as to the Judsons' lawsuit against the city and the police department?
3. What could be done to help prevent further incidences such as what happened to the Brames children?

Key Terms

Ecomaps
Externalized (Behavioral) Problems
Eyewitnesses
Genograms
Internalized symptoms
Multimethod approach
System of safety

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Perpetrators of Intimate Partner Violence

12

Louis Vuitton Does Not Spell Forgiveness

A married friend once joked that if her husband weren't such a screw up, she wouldn't have any nice jewelry. She's told this joke many times in response to a compliment about something she was wearing, and it never fails to elicit laughs.

Socially, we are taught that gifts are selfless, thoughtful and virtuous expressions of love, friendship or respect. We are also taught that a gift is a "get out of trouble" card. And the more expensive or rare or sentimental the gift, the more forgiveness it can barter.

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People who screw up are taught that gifts can be traded or at least leveraged for forgiveness. How many women might instinctively soften after a quarrel if their husband or boyfriend brought home a shiny necklace or stylish watch the next day? How many would take the gift without an explicit admission of guilt? And would that be wrong?

The tricky part of this equation is that gifts can be really nice to get. A gift is a tangible object that says, "I was thinking about you." But it doesn't mean "I acknowledge, understand and take responsibility for what I've done."

Another friend presented a scenario that made this point glaringly clear. She walked into a party with the latest Louis Vuitton handbag, a Marc Jacobs design in tribute to Steven Sprouse. I had seen the bold graffiti-print handbag in magazines. I made note of it on her arm because it sells for about $1,200.

When I cocked an eyebrow toward her stylish new accessory, she said that it was a present from her ex-boyfriend. He's been sending her a parade of gifts ever since they broke up. They broke up because he tried to beat her up. "Gifts can be extremely confusing because it's also consistent with chivalry, and he knows that," [stated] Peter Hovmand, an assistant professor of social work at Washington University. "It's behavior that's intended to create confusion."

He said that gifts can often confuse women about the intent of the giver. Is he a nice guy who had a bad day or is he trying to buy you off so that he can continue that behavior?

Hovmand said that abuse is a learned behavior that is constantly being improved upon. That's an eerie thought. He said that if a guy gave a girl flowers and she didn't forgive him before, this time he might opt for a more expensive gift.

If he hit a girl on the first date and she ran away, he might wait a few months the next time, a year the time after or just until after marriage on the next.

Abusive men he's worked with don't have problems getting dates. He said that actually, abusive men tend to have an easier time charming a new woman than a nonabuser, perhaps because they are more predatory and persistent.

He said that the stereotype of the anti-social manipulator with the feeble cow-towed spouse isn't necessarily the norm. Confident, successful women can also be victims. Perhaps because they tend to attract even more confident and successful men. The kind of men that even your friends have a hard time believing would hurt you.

Chris Brown reportedly sent Rihanna a diamond necklace and bracelet and an iPod Touch for her birthday following this year's highly publicized domestic violence incidence. That was before they reconciled.

My friend with the Louis Vuitton bag told me that I was one of the first people who immediately applauded her decision to take a step back from the relationship after he tried to cause her physical harm. Al-

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most all of her other friends wondered why didn't she give him another chance.

"Friends don't often understand how significant domestic violence can be," explained Ellen Reed, an executive director at Lydia's House, which provides transitional housing and counseling for battered women.

She said that friends might see a charming, attractive, generous guy, but the woman in the relationship needs to ask herself if she's afraid of him. And beware of gift horses. (Bass, 2009)

—Reprinted from the May 2, 2009, issue of the *St. Louis Post-Dispatch* (MO).

In this chapter, the characteristics and typologies of intimate partner violence (IPV) perpetrators are reviewed as well as methods to determine their level of lethality and motivation to change. Many perpetrators are treated in **batterer intervention programs (BIPs)** which attempt to change their cognitive and behavioral patterns, thus discontinuing their abusive acts. Information about such interventions—including underlying theories, interviewing techniques, and recommendations for **program evaluation**—are discussed in this chapter.

While reading this chapter, readers should remember the ongoing debate as to gender symmetry (introduced in Chapter 7). In much of this chapter, perpetrators are referred to as male. However, new research is focusing on domestic violence with female perpetrators and male victims (for example, see Hamel & Nicholls, 2007; also see Chapter 13). We now know that new strategies are needed to reach out to male victims and to treat female abusers.

Characteristics of Perpetrators

Many perpetrators of IPV desire power and control over their victims, which is exhibited in a variety of ways including physically, psychologically, financially, and sexually. The power and control wheel (Domestic Abuse Intervention Project, n.d.) is a snapshot of the numerous strategies perpetrators use to control their victims, including (a) intimidation, (b) emotional abuse, (c) isolation, (d) minimization and denial of the abuse while blaming the victim, (e) misuse of children, (f) male privilege, (g) economic abuse, and (h) coercion and threats. A more in-depth coverage of these strategies is presented in Chapter 8.

Many perpetrators have a history of child abuse (Lyndon, White, & Kadlec, 2007). They may have been physically, sexually, or emotionally abused, have witnessed IPV, or have been maltreated in some other manner (Torres & Han, 2003; White & Widom, 2003). According to Rosenbaum and O'Leary (as cited in Rosenbaum & Leisring, 2003, p. 9), "Approximately 45% of male batterers have witnessed domestic violence in their family of origin . . . [and] approximately 61% have been the victims of child physical abuse while growing up. Perpetrators who have suffered childhood abuse may have untreated posttraumatic stress disorder (PTSD). In a study of 118 men referred to a batterers'

treatment program, 12.7% met or exceeded the cutoff for PTSD on the PTSD Checklist (PCL-C; Weathers, Huska, & Keane, 1991) as compared with the 8% of men in the general population (American Psychiatric Association, 2000). As compared to 149 men in a comparison group, the 118 "partner abusive men" (Rosenbaum & Leisring, 2003, p. 10) were more likely to have been beaten by their mothers, less likely to be told they were loved by their parents, and less often reported to have their fathers watch them perform in school activities or sports (Rosenbaum & Leisring, 2003).

"Most often, one form of violence in the home is an indicator that other family members are at risk" (Onyskiw, 2007, pp. 8–9). The overlap between IPV and child abuse is estimated to be between 30% and 60% of the families reported for one or both types of family violence (Edelson, 1999).

Substance abuse may also co-occur with IPV. Some researchers suggest that substance abuse is involved in anywhere from 20% to 80% of domestic violence cases (Gondolf, 1995). Others have projected that alcohol use is involved in more than half of IPV cases (Caetano, Schafer, & Cunradi, 2001). In such cases, **conjoint treatment** for both substance abuse and partner violence increases success in achieving healthy cognitive and behavioral changes in perpetrators (Gondolf, 1995). The goal of programs using this conjoint treatment approach is to have the perpetrators discontinue abuse of substances and, simultaneously, become resocialized in intimate relationships.

Common characteristics of IPV perpetrators include low self-esteem, excessive dependency on and jealousy of their partners, and poor communication skills (Lyndon et al., 2007; Zosky, 2005). "Problems with impulse control are central to many psychological and behavioral disorders . . . [and] Impulsiveness and Impulsive Aggression [were found] to be significant predictors of self-reported spousal violence" (Edwards, Scott, Yarvis, Paizis, & Panizzon, 2003, pp. 4, 12). A combination of these characteristics increases the likelihood of the individual learning violent behaviors and then utilizing them against a partner (Lyndon et al., 2007).

Causal Theories and IPV

In this section, various levels of theories attributed to causation of IPV are discussed. Theories can be classified as *micro* (addressing individuals), *mezzo* (addressing families and groups), or *macro* (addressing organizations and communities; Kirst-Ashman & Hull, 2009). All three levels of theories have been attributed to the underlying cause of IPV. For each theory, a corresponding intervention is mentioned; interventions will be further addressed under "Intervention/Treatment for Perpetrators" later in this chapter.

Family Systems Theory

Bowen's **family systems theory** (Bowen, 1966)

> *is largely conceptualized at the mezzo level of interpersonal dynamics that occur between partners involved in abuse. . . . The theory is quite eloquent in its description of the interplay of action; however, this theory has difficulty*

moving beyond description to the explanation of why some people inflict violence in relationships. (Zosky, 1999)

Bowen's theory has two core processes—differentiation and chronic anxiety. Differentiation is "the degree to which one is able to balance the emotional and intellectual functioning and the intimacy and autonomy functioning in relationships" (Bowen, 1978; Faber, 2004, p. 123). Chronic anxiety does not occur in response to a real threat, but rather, "it is fed by fear of 'what might be'" (Kerr & Bowen, 1988; Faber, 2004, p. 124). People with a low degree of differentiation experience a high level of chronic anxiety, which can be debilitating to a marriage (Faber, 2004). As tensions in a home become heightened, emotional connectedness among family members becomes stressful, which, presumably, can result in IPV.

Using Bowenian family systems theory in a therapeutic setting, clinicians gather information from couples about the emotional processing that takes place between them (Faber, 2004). Acting in the role of facilitator, the clinician enters a psychoeducational process of teaching and demonstrating differentiation. Bowenian "can be a great tool in helping motivated couples to understand their emotional process" (Faber, 2004, p. 129).

A major criticism about using a family systems approach with perpetrators and victims of IPV is the possibility that the perpetrator will not be held accountable for the violent acts; rather, the victim, and not the perpetrator, will be "blamed" for the violence. Because of this potentially damaging outcome, the family systems theory is not recommended by many in instances of IPV (Stubbs, 2007; Walker, 2009).

Feminist Theory

According to Carden (as cited in Zosky, 2005, p. 44), the **feminist theory** "conceptualizes domestic violence at the macro or sociopolitical level of how men are acculturated into roles of power and women are urged to adopt social roles of passivity." The feminist theory and therapeutic process are based on three principles (Worell & Remer, 2002): (a) the personal is political, (2) egalitarian relationships, and (3) valuing the female perspective (Bitter, Robertson, Healey, & Cole, 2009, p. 17).

Feminists believe that social and political action is an important part of the therapeutic process. Feminists also believe that relationships should be egalitarian, meaning all persons would have equal access to society's institutions and privileges. Power imbalances are to be dissolved in favor of shared power. Valuing the female perspective entails challenging the deprecation to women that is evident in stereotypes, language, and opportunities (Bitter et al., 2009).

Feminist theories are incorporated into therapeutic approaches for working with victims and perpetrators of IPV. Adler (1931, 1938) was among the first 20th-century psychologists to adopt the feminist approach into his work with clients (Bitter et al., 2009), which could be used in intervening with female victims of IPV. Using **Adlerian therapy**, clinicians form egalitarian relationships with their clients, get to know them as people, and seek to understand the influence of the dominant culture on them. They assist their clients in reframing old experiences and in creating and practicing new ones (Bitter et al., 2009).

The **Duluth model** is another **psychoeducational** intervention for working with perpetrators of IPV (Aymer, 2008) which is also based on feminist theories. In this model, counselors seek "to debunk men's stereotypical beliefs about women" and to replace power and control relationships with equality relationships (Aymer, 2008, p. 323).

Therapeutic approaches based on the feminist theory have been criticized for not differentiating between men from patriarchal cultures who abuse from men who do not abuse (Zosky, 1999). Why do some abuse and others do not? The other criticism is this theory's practicality for clinical application at the micro level (Zosky, 2005). "The addition of micro level theories such as object relations theory, attachment theory, and the developmental theory may add to our ability to understand why some men engage in domestic violence" (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Zosky, 1999; Zosky, 2005, p. 44).

Object Relations Theory

Margaret Mahler's theory of the *separation–individuation process* (Mahler, Pine, & Bergman, 1975) was derived from *psychoanalytic theory* and described "how the infant evolved into a separate psychological individual" (Zosky, 2005, p. 46). Mahler theorized that during the first 2 months of life, an infant goes through the *autistic* phase and concentrates on the physiological aspects of life. The next phase, the *symbiotic* phase, is experienced from 2 to 15 months, during which the infant attaches to others. The last phase, *separation–individuation,* spans from 6 months to 3 years, during which the infant acquires the ability to differentiate self from others.

Object relations theory builds on these concepts and suggests that perpetrators were unable to successfully separate themselves as infants, perhaps because of poor mothering and insecure attachment (Zosky, 2005). They were not loved unconditionally; many were abused as children. They became unable to relate to others as whole beings. They use their "partners to unconditionally satisfy their needs . . . [which] explains the intense need to control and sense of jealously that many batterers engage in" (Zosky, 2005, p. 50). "Due to [perpetrators'] early developmental damage, Hockenberry (1995) suggests that although it is appropriate to hold batterers accountable, clinicians still need to engage in an empathic supportive relationship style" (Zosky, 2005, p. 57).

Attachment Theory

Attachment theory, originally presented by Bowlby (1969), proposes that human survival is dependent upon secure attachment of a child to another figure. Upon being alarmed by any source, an infant seeks out soothing physical contact with the attachment figure (Sonkin & Dutton, 2003). Only physical contact with the attachment figure will terminate the alarm. If the infant is not soothed for an extended period of time, the infant becomes angry. Thus, "anger is an emotion 'born of fear' of loss" (Sonkin & Dutton, 2003, p. 106). The theory translates to perpetrators, who either are preoccupied with their partners' behavior or show patterns of approach/avoidance (ambivalence). Dutton (1998) described "the 'abusive personality,' as a constellation of psychological traits that, when assessed in males are highly related to partner's reports of abusiveness"

(Sonkin & Dutton, 2003, p. 106). Sonkin and Dutton (2003) recommended that the attachment theory be further studied as to its applicability for working with perpetrators.

Cognitive–Behavioral Theories

Cognitive–behavioral theories are based on the assumption that violence is a learned behavior; therefore it can be unlearned (Adams, 1988). People behave in a certain manner because it relieves pressure and is functional for them (Babcock, Green, & Robie, 2004). Batterer intervention programs (BIPs) based on these theories use communication, assertiveness, social skills training, and anger management techniques to teach individuals more positive and socially acceptable ways of thinking and behaving (Babcock et al., 2004).

Family Health Perspective

The family health perspective (Pardeck & Yuen, 1999) may be helpful in intervening with families experiencing domestic violence. As described in Chapter 1, this perspective combines systems, ecological, and social constructionist theories and emphasizes all aspects of the individual and the family (social, emotional, psychological, physical, financial, social, and cultural). Treatment strategies include empowerment, use of the strengths perspective, and collaboration among professionals.

Rather than concentrate on any one theoretical base for a program, Smith (2007) chose to understand the perception of men, who had been court ordered into a BIP, in terms of their feelings and thoughts before attending the program. She interviewed 14 men and had particular interest in their emotional intelligence. Smith found two major themes in their experience. They minimized their behaviors toward their victims and considered the victims' actions toward them as unjustified. They felt victimized, humiliated, and shamed. They blamed the victim and denied any shared blame (Smith, 2007). Smith emphasized the self-deception these men used to cover any feelings of responsibility and recommended that programs be geared to increasing men's emotional intelligence.

Typologies of Perpetrators

Gelles and Straus (as cited in Kantor & Jasinski, 1998) identified 15 theories organized into three broad categories, which attempt to explain the underlying causes of abusive behaviors: (a) the **individual/intrapersonal model**; (b) the **interpersonal model**; and (c) the **sociocultural model** (Bersani & Chen, 1988).

The *intraindividual/interpersonal models* emphasize individual causes of abusive behaviors such as substance abuse (Gondolf, 1995); psychological factors such as self-esteem (Hamberger & Hastings, 1986); antisocial personality disorders such as borderline personality disorder (Holtzworth-Munroe & Stuart, 1994); and biological/neurological factors such as attention deficit disorders and head injuries (Warnken, Rosenbaum, Fletcher, Hoge, & Adelman, 1994).

These theories draw attention to the variations in psychological pathologies among batterers (Kantor & Jasinski, 1998).

According to Kalmuss, O'Leary, and Straus (as cited in Kantor & Jasinski, 1998, p. 14), the *sociocultural models* stress "social learning through experience and exposure to violence in the family." The sociocultural theories focus on causes of abusive behaviors that are embedded in social location (income and education; Kaufman Kantor, Jasinski, & Aldarondo, 1994). The feminist perspective, which addresses the imbalance of power between genders, is related to the sociocultural theories (Pagelow, 1984).

Three subtypes of IPV perpetrators were proposed by Holtzworth-Munroe and Stuart (1994): (a) family only (FO) type; (b) borderline/dysphoric (BD) type; and (c) generally violent/antisocial (GVA) type. *Family only* batterers tend to engage in low levels of violence and pose little risk. Their abuse is related to situations such as stress at work. They typically show a high level of remorse and an eagerness to maintain their relationships with their partners. The *borderline/dysphoric* batterers engage in moderate to severe marital violence and evidence psychological distress and borderline personality disorder characteristics. BD batterers are dependent, jealous, and hostile toward women. *Generally violent/antisocial* batterers engage in severe abuse. They are antisocial, impulsive, and aggressive; they are violent at home and in general (Holtzworth-Munroe & Stuart, 1994).

Assessment With IPV Perpetrators

Assessments with perpetrators are best approached through establishing a culturally sensitive, positive working relationship. Using aggressive and confrontational strategies increases clients' resistance and defensiveness, thus, proving counterproductive (DiClemente, Bellino, & Neavins, 1999).

Prior to the assessment, the usual therapeutic activities need to occur, such as informing clients of confidentiality and having them sign release forms. In addition, they need to be informed about the laws and potential ramifications of committing violence against another person, such as prison, loss of work, inability to possess a firearm, and probation. Using an information-sharing approach, therapists help perpetrators to acknowledge the negative impact of their behaviors on themselves, their partner, and their children.

Lethality

Lethality refers to perpetrators' level of dangerousness, which is determined by a combination of professional judgment and the use of risk assessment instruments. The higher the risk, the more dangerous these persons are to themselves and to their partners (Hoyle, 2008). Perpetrators' level of lethality is dependent on a combination of factors that require assessment (Humphreys, 2007). The probability of violence increases if perpetrators abuse substances, exhibit extreme jealousy, have a history of violent attacks, or have mental health issues (Humphreys, 2007). The risk of harm increases if children are in the home. Additional concern about lethality is warranted if perpetrators have threatened

to commit suicide if their partner leaves them or have threatened homicide (Humphreys, 2007).

Motivation to Change

In addition to determining perpetrators' level of lethality, clinicians must determine their motivation to change. Perpetrators' motivation is highly related to their success in discontinuing violent behaviors (Dutton, 1998). Because the majority of perpetrators enter counseling because they are mandated to do so by the courts, many are highly resistant to treatment and lack the motivation necessary to change their behaviors (DiClemente et al., 1999).

The **transtheoretical model** (TTM) theorizes that there are five stages of change (Prochaska, DiClemente, & Norcross, 1992). During the *precontemplation* stage, perpetrators do not believe their violence is a problem; they may blame other people for their violent behaviors. The *contemplation* stage is the period in which perpetrators first consider the pros and cons of changing. The *preparation* stage marks an increase of the commitment to change and leads to the *action* stage. At this point, perpetrators are ready to accept assistance and take action to change their behaviors. Finally, during the *maintenance* stage, perpetrators attempt to maintain the new behavior.

The movement from one stage to the next can be approached using numerous techniques depending upon the philosophy of the social worker (or program), the internal motivation of the perpetrator, and the perpetrator's ecology (environment). Each provides either additional motivation or poses barriers to recovery. Social workers are responsible for determining means for motivating perpetrators by assessing what is important to them, such as keeping their families, staying out of jail, or not losing work. Providing motivation for these intrinsic (internal) needs is often more effective than motivation through extrinsic (external) means, such as financial incentives (DiClemente et al., 1999). (For a broader discussion of motivational interviewing techniques in the field of IPV, see Murphy & Maiuro, 2009.)

Assessment Tools

Assessment tools provide an evidence-based measure for assessing a client's situation. Many of these tools are simple to administer and analyze (Ammerman & Hersen, 1999). Useful sources of assessment tools include Fischer and Corcoran (2006); McCubbin, Thompson, and McCubbin (1996); and Buros (2003). Specific measures include:

- The Conflict Tactics Scale (CTS; Straus & Gelles, 1992)—determines the severity of physical violence among cohabitating and married couples (Edwards et al., 2003)
- The Danger Assessment Scale (DAS; Campbell, 1995)—15-item yes/no questionnaire on risk factors associated with IPV homicide
- The Spousal Assault Risk Assessment Guide (SARA; Knopp, Hart, Webster, & Eaves, 1995)—20 items to enhance professional judgments about risk

- The Propensity for Abusiveness Scale (PAS; Dutton, 1995)—5-point Likert scale to determine personality factors associated with abusive behaviors
- The Lifetime History of Aggression Questionnaire (LHAQ; Coccaro, Berman, & Kavoussi, 1997)—Likert scale on aggression, antisocial behavior, and self-destructive behavior
- The Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989)—567 items of 10 clinical personality scales including paranoia, social introversion, and depression
- The PTSD Checklist-Civilian Version (PCL-C; Weathers et al., 1991)—17 items on PTSD symptoms according to DSM-IV
- The Buss and Perry Aggression Questionnaire (Buss & Perry, 1992)—29-item Likert scale to measure physical and verbal aggression, anger, and hostility

Intervention/Treatment for Perpetrators

"Relationship aggression is a complex problem. We now accept that batterers and their partners are diverse populations and it is ludicrous to seek or accept simple explanations for intimate partner aggression." (Rosenbaum & Leisring, 2003, p. 8)

> *There is no general consensus about which programs work best, though it is clear that both the content and the clientele differ depending on factors such as region of the country where the program is located, proportion of court-mandated clients, training and orientation of staff, length of program and cost. (Nason-Clark, Murphy, Fisher-Townsend, & Ruff, 2003, p. 55)*

The quotations above demonstrate the complexity of working effectively with perpetrators of IPV. The following sections examine some common intervention models.

Walker (2009) presents three major models for treatment programs. Among the most popular is the *Duluth model,* based on the feminist perspective and referred to earlier in this chapter. The second model combines treatment for IPV and mental health problems such as AMEND (www.amendinc.org) and EMERGE (www.emergedv.com). The third is made up of mental health treatment programs that do not include the sociocultural feminist perspective (Walker, 2009, p. 321). While recognizing the benefits and limitations of the Duluth model in stopping perpetrators from repeating their abusive behaviors, Walker (2009) recommends that batterers be screened to assure they have adequate social skills to benefit from a group process such as the one used by the Duluth model.

Dutton (2006) advocates against the "one size fits all" approach to intervention (p. 346). Based on the work of Grauwiler and Mills (2004), Dutton (2006) proposes a "triage" approach to IPV. The highest level includes perpetrators who have committed acts of "terrorism" for which they need to be arrested for the safety of the victim. The second grouping consists of perpetrators who have

committed acts that are not as serious; however, the victim wants the abuse to end. These individuals would receive blended behavioral therapy (Dutton, 2006, p. 342), which is a three-stage program addressing social, biological, and psychological factors (Dutton, 2006, p. 320). The third group comprises individuals who have not inflicted serious injury and for whom the victim does not desire criminal justice proceedings. This group should participate in the Intimate Abuse Circle (IAC) for restorative justice.

> *Restorative justice practice in the area of domestic violence can be rooted in a clear set of values and principles that coincide with mainstream feminists . . . [and has] the capability to be adapted to . . . the concerns of special groups—ethnic or same-sex. (Dutton, 2006, pp. 343, 348)*

"Efforts to reduce complex dynamics to single constructs, such as power and control, have impeded research in this field. So too have attempts to depsychologize battering" (Rosenbaum & Leisring, 2003, p. 8). The first part of the sentence ("power and control") refer to feminist models; the second part ("depsychologize") refers to criminal justice models. Rosenbaum and Leisring define *depsychologizing* as referring to those who believe that battering is a crime and batterers should be incarcerated rather than being provided psychological counseling (p. 8). Rosenbaum and Leisring suggest that this position does not address many psychological issues faced by batterers, such as PTSD and oppositional defiant disorders. Treating these adults purely as criminals has resulted in substituting "intervention" for "treatment" (Rosenbaum & Leisring, 2003, p. 8). "It is difficult to treat [batterers] and not also recognize that many of them are damaged, unhappy, psychologically impaired individuals" (Rosenbaum & Leisring, 2003, p. 19).

Most often, perpetrators are referred to either therapy or a therapeutic program through the courts. (In one study of perpetrators in batterer intervention programs, Gondolf (2002) discovered that 80% of the 840 men in the program were court-mandated.) This referral typically follows a police arrest and an offer by the court to attend therapy rather than go to jail. The mandated nature of many therapy programs typically engenders resistance in perpetrators, which must be overcome before progress can be made.

Most intervention approaches include "feminist psychoeducational men's groups, cognitive–behavioral men's groups, anger management (a form of cognitive–behavioral group treatment), and couples' therapy" (Babcock et al., 2004, p. 1025). The majority (90%) of these models use group formats and run for 12 to 52 weeks (Austin & Dankwort, 1999). "The emergence of batterer intervention programs (BIPs) occurred in the late 1970s and corresponded with the increase of services for victims of domestic abuse" (Schmidt et al., 2007, p. 91).

Daly and Pelowski (as cited in Chovanec, 2009, p. 125) state that "Engaging men who abuse in the change process continues to be a challenge. Dropout rates from domestic abuse treatment programs range from 50% to 75%." Facilitators must understand the change process and how to help perpetrators through the process without discontinuing treatment (Chovanec, 2009). Successful techniques include validation of men's defensiveness, addressing the shame that men feel by being in the program, and providing information to men to challenge them in the change process.

Duluth Abuse Intervention Program (Duluth Model)

"The most prominent type of clinical intervention with batterers is a feminist psychoeducational approach" (Pence & Paymar, 1993), developed at the Duluth Domestic Abuse Intervention Program (Duluth model; Babcock et al., 2004, p. 1026). In the early 1980s, the Duluth model was formed in Minnesota based on the feminist theory and a social work perspective (Babcock et al., 2004; Pence & Paymar, 1993). The curriculum uses an educational and counseling approach, is not considered therapy, and focuses on the "power and control wheel" as well as the "equality wheel" (see Chapter 8). The objectives of the program are to have perpetrators understand their acts were means of control, examine cultural and social contexts in which they used violence, examine negative effects of their behaviors, accept responsibility for their actions, and change abusive behaviors (Pence & Paymar, 1993). Teaching tools included the *check-in,* during which participants explained steps they took to work toward change; *action plans,* or written records of goals and steps toward change; as well as *videos, role-play,* and *group exercises* (Pence & Paymar, 1993).

Domestic Abuse Education Project (DAEP)

The Domestic Abuse Education Project (DAEP) is established in Vermont and combines aspects of the Duluth model with a cognitive–behavioral approach for IPV intervention (Schmidt et al., 2007). The program's objective is to expand men's understanding of behaviors used to control their female partners, increase their awareness of their intentions that support their choices to abuse, increase their understanding of negative consequences of their behaviors, encourage them to take responsibility for their behaviors, motivate them to change, and provide support for ensuring their partners' safety (Schmidt et al., 2007).

Domestic Violence Prevention Service (DVPS)

The Domestic Violence Prevention Service (DVPS) program uses systemic group work, combined with the Duluth model, to counsel male batterers of heterosexual IPV (Rivett & Rees, 2004). The DVPS method includes "working within a system of agencies, retaining a systems perspective in the programme and using techniques from the systemic tradition in the group work programme itself" (Rivett & Rees, 2004). Police protection and crisis intervention are in place to assist victims. Using this systemic perspective, the program tries "to deconstruct the wider systems which both support misogyny and promote male privilege while working in a multiagency arena to increase the safety of children and women" (Rivett & Rees, 2004, p. 158).

Cognitive–Behavioral Versus Process–Psychodynamic Groups

Chang and Saunders (2002) compared outcomes of two different treatment groups for men who batter. The cognitive–behavioral treatment (CBT) group combined cognitive–behavioral and feminist perspectives using a "combination of cognitive restructuring, relaxation/desensitization training, behavioral rehearsal, and consciousness-raising" (Chang & Saunders, 2002, p. 275). The

group was highly structured and was taught alternatives to aggression. The leader modeled behaviors and guided the men in rehearsals, using, among other techniques, confrontation.

The process–psychodynamic group (PPG) stressed emotional attachments, personality, and childhood traumas. This group was less structured and encouraged men to express their feelings. Of the two, the study found that the PPG treatment was more successful in retaining clients except for men who had experienced child abuse (the researchers theorized that exchanging feelings may have raised childhood traumas that they were unable to handle; Chang & Saunders, 2002). Recommendations included the provision of services that are tailored to specific needs to those most likely to drop out.

Solution-Focused Treatment

Solution-focused treatment programs include both male and female offenders that explore the batterers' history and their potential to cooperate, develop solutions, and manage anger (Lee, Uken, & Sebold, 2004). Perpetrators are to focus on a personally meaningful goal (e.g., controlling anger), on relationships (listening to spouse), and on attitudes (taking responsibility). The group focuses on successes of participants, uses language that is positive and change focused, and holds participants responsible for reaching their goals (Lee et al., 2004). The focus is on the present and future using a collaborative therapeutic relationship.

Strengths-Based Approaches

Strengths-based programs focus on the perpetrators' strengths and attempt to utilize those strengths to change their violent behavior. "Because participants selected and determined their personal goals, they were more likely to perceive the treatment as beneficial and personally meaningful, which probably increased their motivation to complete the program" (Lee et al., 2004, p. 472).

Psychotherapeutic Approaches

The attachment theory (Bowlby, 1969) has been incorporated into the psychotherapeutic approach for treating batterers of heterosexual IPV (Sonkin & Dutton, 2003). The primary task to addressing attachment in psychotherapy is development of the secure base (Sonkin & Dutton, 2003, p. 111). This task is particularly difficult with batterers because they tend to have developed insecure attachment styles known as avoidant (e.g., lacking empathy), preoccupied (clingy and angry), and disorganized or fearful (fear of rejection; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000).

Therapists may succeed at developing a secure base for batterers using "secure base priming" (Sonkin & Dutton, 2003, p. 115). Mikulincer and Shaver (as cited in Sonkin & Dutton, 2003, p. 115–116) hypothesized that "having a secure base could change how a person appraises threatening situations into more manageable events without activating insecure attachment-behaviors." The therapeutic process includes exploring childhood experiences and their influence on the client including overcoming former experiences with attachment figures

and exploring pathological aspects of the batterers' personality. (For a complete explanation of attachment within the psychotherapeutic process, see Sonkin & Dutton, 2003.)

Summary

Perpetrators are a heterogeneous group (Stuart & Holtzworth-Munroe, 1995). Different individuals benefit from different types of treatment (Stuart & Holtzworth-Munroe, 1995). Group treatment tends to be the most popular (Pence & Paymar, 1993); however, individual (Sonkin & Dutton, 2003) and conjoint (Harris, 2006) approaches also are used. Overall, "there is little empirical evidence that treatment is effective in reducing recidivism of family violence to any meaningful degree" (Babcock et al., 2004, p. 1024).

Program Evaluation

Babcock and colleagues (2004) conducted a meta-analysis of 22 studies as to the effectiveness of various IPV treatment programs. Major problems with the state of program evaluations involve methodological issues. More specifically, quasi-experimental studies lack randomization and control groups. In addition, dropout rates and the means for determining effect size and risk of confounds resulted in only five studies meeting "true experiment" standards (Babcock et al., 2004, p. 1031). "Because no one treatment model or modality has demonstrated superiority over [the] others, it is premature for states to issue mandates limiting the range of treatment options for batterers" (Babcock et al., 2004, p. 1048).

In his study of 150 BIP directors from 35 states, Dalton (2007) reported the average cost of programs, which charge using a sliding-fee scale (clients pay in relation to what they earn), was $38.45 per visit; "the most commonly cited source of client referrals was from the judicial system" (p. 67); and almost 100% served White male perpetrators. Information on different treatment tracks, means for screening clients, and matching clients to appropriate intervention was largely missing (p. 70). "Often the best-intentioned efforts are guided as much by personal opinion, tradition, and clinical experience as by empirically informed knowledge of what works" (Dalton, 2007, p. 72).

Summary

In working with perpetrators of domestic violence, social workers gather, analyze, and synthesize information to determine their background, the severity of abuse, their lethality, and their motivation for change. Based upon the assessment, treatment is planned and implemented in conjunction with the perpetrator both to assure the victim's safety and to assist the perpetrator in changing violent behaviors. Various theories attempt to explain the underlying causes of abusive behaviors. Matching theoretical approaches and individual characteristics remains one of the principal difficulties in locating appropriate intervention modalities.

Family Violence Spikes Here—Area Police, Experts Say Recession May Be Fueling Increase

The police say domestic violence and child abuse are soaring in the city of St. Louis.

Children's hospitals say they're seeing more—and more severely—shaken and beaten children from both sides of the river.

A crisis nursery says it has a record caseload and had to turn away more than 200 children in March for lack of bed space.

Police and other family violence professionals say these could be signs that the recession is fueling violence in St. Louis-area homes.

The magnitude is difficult to assess. Some agencies are reporting recent spikes in domestic violence and child abuse, and attributing them to the economy.

Others show no changes. Notably, the Missouri Department of Social Services shows no recent uptick in child abuse and neglect. And administrators at two local shelters say they aren't seeing a rise in battered women seeking help, although experts say that could mean women are too afraid to leave an abuser during hard times.

Still, the St. Louis police chief is at a loss for another way to explain a sudden rise in family violence while, overall, reports of crime are down.

"That's really the only explanation to have such a dramatic increase in child abuse and domestic abuse at a time when the unemployment rate is up," said Chief Dan Isom. He said the department is working with St. Louis Children's Hospital to study the problem.

The city had 284 domestic violence cases in the first quarter of this year—up 52 percent from the same period a year ago. Children didn't fare much better, with 108 incidents of child abuse, up 46 percent, he said.

St. Louis County police saw a 27 percent increase in domestic violence cases in the first quarter. They were still tabulating child abuse cases.

"It's the economy," said county police Sgt. Tracy Panus. "Our guys are hearing, 'I lost my job, I'm going to lose the house, bills are piling up.'"

On March 31, an unmarried couple were at a restaurant in south St. Louis County with their five children when they began to argue. The father had just been laid off from a trucking job. He beat up the mother in front of the kids, said Panus.

"When the officers were interviewing him, he made statements about how stressed out he was over his job situation and not being able to support his family," she explained.

In the city, abuse suspects generally aren't citing the recession as a defense.

It's just that there are so many more cases, said spokeswoman Erica Van Ross. "It mirrors the timing of the economy tanking."

(continued)

F. Brett Drake, associate professor in Washington University's George Warren Brown School of Social Work, said research shows that a poor economy leads to increased family violence.

Economic difficulties don't usually cause someone who has never been abusive to suddenly become violent, said Colleen Coble, chief executive officer of the Missouri Coalition Against Domestic and Sexual Violence. But with abusers, economic hardship "most typically increases the severity of the abuse—and the frequency."

Social workers at two major children's trauma centers say they have seen an increase in young patients brought in from both Missouri and Illinois.

St. Louis Children's Hospital said it treated 82 abused children in the first quarter of this year—five of whom died. There were 59 cases in the first quarter of last year, none fatal.

"As soon as they arrive in the ER, you can see when they present that the (caregivers) are extremely distraught," said Margie Batek, lead social worker at Children's Hospital. "In reviewing these cases, you hear the statements they make to the physicians and to law enforcement. They 'didn't mean to.' They 'lost patience.' The baby 'was crying for a long period of time.'"

"These are people who for whatever reason aren't able to deal with the stress of the moment," she said. "I don't know what those stresses are, but when you have layoffs and high unemployment, it's not at all surprising."

Statewide hot lines for domestic abuse victims saw an 8 percent rise in calls for help last year, and a St. Louis-based counseling service saw its caseload double for couples in abusive relationships.

Such a spike often means the agency will see an increase in child abuse referrals down the line, according to officials from Family Resource Center, an agency that counsels abusers.

Almost 40 percent of the time, in the agency's experience, one goes with the other. It's called "co-occurrence." National studies say it could be happening more often—up to 60 percent of the time.

Even in cases where economic trouble doesn't spark family violence, it can push a parent into making poor decisions that put their children in jeopardy.

Social workers say they think some parents are cutting corners with child care, leaving babies and young children with people who don't know how to—or don't want to—care for kids.

"Families can't afford it so they leave the kid with whatever warm body will watch the child," said Donna Erickson, lead social worker in the emergency room at Cardinal Glennon Children's Medical Center. "A lot of our mothers rely on boyfriends to provide child care. They fool themselves into believing that they would not hurt their children, and that's a fallacy."

Last month, a young woman in Riverview left her 14-month-old daughter in the care of her boyfriend, 18, and came home from a night shift to find the toddler slain in what prosecutors called one of the worst abuse cases they'd ever seen. The boyfriend was jailed on a charge of first-degree murder.

(continued)

Suzanne McCune, who is responsible for collecting data on Missouri child deaths, said fatal abuse cases have become disturbingly brutal.

In some cases, infants and toddlers were tortured in a period of rage prior to receiving a fatal blow, said McCune, an administrator for the St. Louis County medical examiner's office.

"The evidence of repeated assault, where a child is beaten and thrown and burned and shaken—there were several fatalities like that in the last year."

She said that parents in trouble do have places to go for help. . . . The number of parents needing help . . . because of "parental stress" increased by more than a third.

Most said they were struggling with economic stress, Eckardt said. (Kohler & Cambria, 2009)

—Reprinted from the April 17, 2009 issue of the *Springfield News-Leader* (MO).

Discussion Questions

1. What is your opinion of the relationship between economic hardships and IPV?
2. In your opinion, of the treatments presented in this chapter, what type of treatment is most appropriate for men such as the man who beat his wife in front of the children at the restaurant?
3. In question 2, how would you go about conducting an assessment of the couple and their children?
4. What types of intervention are viable for families who are experiencing economic hardships?

Key Terms

Adlerian therapy
Attachment theory
Batterer intervention programs (BIDs)
Cognitive–behavioral theory
Conjoint treatment
Duluth model
Family systems theory
Feminist theory
Individual/intrapersonal model
Interpersonal model
Lethality
Object relations theory
Program evaluation

Psychoeducational
Sociocultural model
Transtheoretical model

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Intimate Partner Violence Among Diverse and At-Risk Populations

13

Not a Laughing Matter

The incident was first reported in a brief item in the *Post-Dispatch* under the headline: "Warm beer spurred shooting, police say." The story later circled the globe, becoming the punch line of jokes and eventually landing back in the *Post-Dispatch* as a front-page tale of one family's tragic loss.

Absent from the coverage of the fatal shooting of 71-year-old Robert Booker Jones by his wife of 25 years, Corine Jones, was the very real—and decidedly unfunny—story of domestic violence in St. Louis and around the country.

An estimated 90 percent of domestic violence victims are women. Every year, millions of women are punched, choked, shoved, slapped,

(continued)

stabbed or sexually assaulted by a boyfriend or husband. Because most of the attacks are not reported to authorities, no one knows the exact number. An estimated 2 million women every year suffer injuries, according to the Centers for Disease Control and Prevention. On average, 4 women are killed by a domestic partner every day.

When a man is attacked by a woman—especially when the precipitating factor seems trivial or bizarre, like a warm beer—it captures the attention of the media. As news of Mr. Jones' murder made its way around the world, Jay Leno poked fun. An MSNBC headline snickered: "Hot lead for warm beer."

Experts say we pay lip service to the issue of domestic violence, but we still don't take it seriously. Its victims often are judged harshly by those who assume the victims were enablers, or complicit in some way with their abusive intimate partners. Studies have found that bystanders are less likely to intervene in a physical dispute if they think the people involved are in a relationship. Even family members and police are reluctant to intervene.

In Missouri, law enforcement agencies reported about 40,000 incidents of domestic violence in 2004, according to the National Coalition Against Domestic Violence. In Illinois, a domestic crime is reported every four minutes, the coalition reported.

Domestic violence is a deep-rooted, complex and multi-faceted problem, with complex and multi-faceted solutions. But one thing it clearly is not: a joke. (Editorial, 2006)

—Reprinted from the December 20, 2006, issue of the *St. Louis Post-Dispatch* (MO).

This chapter focuses on the effects of IPV on victims of diverse cultural backgrounds and/or **at-risk populations**—those who suffer **social and economic injustices**. As both victims of partner violence and members of a diverse culture, they suffer "multiple jeopardy" (Butler, 1999, p. 183), which adds barriers in their efforts to escape from violence. They require services that are provided from professionals trained to be culturally competent.

Social workers must respond to the needs of these victims with more than *cultural knowledge* (familiarity with characteristics of other populations), *cultural awareness* (an awareness of personal attitudes and values and how they are impacted by one's culture) and **cultural sensitivity** (understanding a culture without judging it; Lee & Greene, 2003, p. 6). Rather, they must respond with **cultural competence,** which is the development of a set of behaviors, attitudes, and policies that can work effectively in cross-cultural situations, thus increasing the quality of care (Lee & Greene, 2003).

This chapter presents the barriers experienced by victims who are members of diverse populations, including those who are impoverished, older, living in rural areas, female perpetrators, living with disabilities, immigrants, Asian American, African American, Hispanic, Native American, and partners in same-sex couples.

Women, Welfare, and IPV

Researchers (Hays, 2003; Lyon, 2000; Tolman & Raphael, 2000) estimate that approximately 60% of welfare mothers have been victims of IPV and that from 15% to 34% are current victims of IPV (Roschelle, 2008).

In 1996, President Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which included **Temporary Assistance to Needy Families (TANF)**. In 2005, the act was reauthorized (H.R. 240) to include increased work requirements (which may include employment or "work activities" such as community service or on-the-job training) and marriage promotion grants (Green & Brownell, 2007).

Critics charge that many battered women who need financial assistance may have difficulty meeting the guidelines established by PRWORA. They may be coerced by their husbands or partners to leave their jobs or job training programs, thus making them more dependent on their partners for survival (Green & Brownell, 2007). The "marriage promotion" funds may have the inadvertent effect of encouraging these women to remain with abusive partners (Green & Brownell, 2007).

In consideration of the special needs of battered women who cannot leave their abusers, TANF included the Family Violence Option/Wellstone-Murray Amendment—*42 U.S.C. §602(a)(7)(1996)*—also referred to as the Family Violence Option (FVO; Lindhorst & Padgett, 2005). States are able but not required to adopt the FVO. It provides screening for domestic violence and referrals to support services for women living in violent homes (Davies, 1996). States that adopt the FVO can establish programs, exemptions, and waivers to assist battered women. The FVO also provides more stringent confidentiality than normal welfare guidelines, thus preventing their abusers from finding their victims. Without FVO, welfare would be discontinued if recipients failed to cooperate with child support enforcement, mandatory work requirements, and strict time limits (Lindhorst & Padgett, 2005, p. 405). FVO provides for training to inform victims about domestic violence and victims' rights. Through this legislation, perpetrators can be prohibited from seeing their children (Davies, 1996). Additional services include day care, substance abuse treatment, and mental health care.

Implementation of the FVO often becomes problematic for victims, frontline social workers, and social service agencies (Lindhorst & Padgett, 2005). Victims are often unaware of FVO and therefore fail to take advantage of it. Others are afraid to mention to their social workers that they are victims for fear of losing their children. Agencies have limited resources and may be unable to provide additional services. Advocacy is required on many systems levels if victims on welfare are to obtain the social and economic resources they need to escape the violence in their homes.

Older Battered Women

In 1988, Pillemer and Finkelhor (as cited in Wilke & Vinton, 2003, p. 225) "estimated that the rate of abuse for persons aged 65 and over who were living with

only a spouse was 41 per 1,000 couples. The perpetrators of this abuse were most likely to be spouses (58%)." In their study of 370 women ages 65 and older, Bonomi and colleagues (2007) reported that the lifetime prevalence of partner violence against older women was 26.5%, which is consistent with estimates of IPV on younger women (25.5%; Tjaden & Thoennes, 2000). Despite the increasing recognition of IPV against older women, "correlates of interpersonal violence among midlife and older adults are largely unknown" (Wilke & Vinton, 2005, p. 318).

Although older women are increasingly aware of information and services available to help victims of abuse, they experience unique barriers that preclude their protection (Brandl, 1997). Among these are inappropriate service delivery and inadequate professional training (Osmundson, 1997). These victims are thwarted from seeking help based on the established service delivery systems of Adult Protective Services (APS), which addresses abuses by other than a partner, and domestic violence programs, which are typically aimed at younger victims (Brandl, 1997). Workers from APS typically visit in the home; thus they expose victims to retaliation from their abusers for contacting outside help (Brandl, 1997). Workers from domestic violence programs provide assistance in shelters, which are seldom equipped to provide the special medical attention that older victims may need. Faced with this dilemma, these victims may feel that they are unable to escape their abusers (Brandl, 1997).

The women who do reach out for help are often confronted with professionals who lack the training to provide the necessary services (Brandl & Horan, 2002). Older abused women need information about safety planning, advocacy, and related issues as well as about Social Security, pensions, and other resources. Universal screening by health care professionals would help in identifying these women and providing them the appropriate services (Brandl & Horan, 2002).

Rural Women and IPV

Some research suggests that as many as one-third of women living in rural communities may be victims of domestic violence (Chamberlain, 2002). The lack of research and services to these victims is a phenomenon called **social exclusion**. These women are socially excluded from accessing services for a variety of reasons, most typically involving (a) personal, (b) family values, (c) funding, and (d) structural factors (Hilbert & Krishnan, 2000, p. 41).

Personal and family values may include issues such as poverty and an inability to leave home, even in cases of abuse. Funding exclusions refer to the lack of available services for rural women. Shelters are usually not in accessible locations, and law enforcement cannot respond to emergency calls quickly because of the sheer size of the geographic area being covered (Hilbert & Krishnan, 2000).

Structural exclusions include personal and social factors. Rural victims may be geographically isolated from family, friends, and outside contacts; thus they are unable to find anyone in whom they can confide. Firearms are common in these homes, presenting possibly volatile situations should the victim try to escape (Hilbert & Krishman, 2000). Even if victims do try to escape, public trans-

portation is rare, and personal transportation requires money and access to car keys.

For all these reasons, rural women may find little to no help in escaping from their abusive partners. They need education about safety planning, specialized services including animal care, effective means of protection in their own homes and ways of having the abuser removed, specialized services to complete farm responsibilities if their abuser is removed, transportation, and access to other services (Hilbert & Krishman, 2000).

Female Perpetrators of Violence

Although most traditional research and the literature addressing partner violence between heterosexual couples focuses on female victims and male perpetrators, increasingly men are being recognized as the victims of female perpetrators. In their National Family Violence Survey, Straus and Gelles (1986) concluded that male and female IPV perpetrators were similar in prevalence, severity, and motivation. Since that time, researchers have further explored issues of gender and IPV (Archer, 2000; Hamel & Nicholls, 2006 Johnson, 2005;).

Archer (2000) reported that different methods of measurement produce conflicting results as to violence and its outcome by gender. Women are more likely than men to use more than one act of physical aggression; whereas men are more likely to inflict an injury to their female partner when they become aggressive. "On average, each year from 1992 to 1996, 8 of every 1,000 women were physically and/or sexually assaulted by a current or former [partner] compared to 1 out of 1,000 men" (McFarlane, Willson, Malecha, & Lemmey, 2000, p. 158). When the acts are aggressive, "injuries resulting from male to female aggression occur more frequently and tend to be more severe than injuries resulting from female to male aggression" (Leisring, Dowd, & Rosenbaum, 2003, p. 258).

Straus (1993) estimated that, among violent couples, women were the aggressor in 25.5% of cases, men were the aggressor in 25.9% of cases, and both partners were violent in 48.6% of cases. However, Leisring et al. (2003) reported that women who have been arrested for IPV have been described as acting in self-defense (Hamberger, 1997); therefore determining how many women are the principal aggressors is difficult.

"Relationship aggression affects all family members in destructive ways" (Straus & Gelles, 1990). "Aggression perpetrated by women, as well as by men, negatively affects child witnesses" (Jaffe, Wolfe, & Wilson, 1990; Leisring et al., 2003, p. 260). Women who are aggressive need treatment that is specifically designed to be effective with them.

In working with female perpetrators, assessment should include the initiator of the violence, the histories of violence by both partners, and their reasons for the violent behaviors (Hamberger, 1997). Group treatment has proven helpful for working with aggressive IPV-prone women (Leisring et al., 2003). Such groups can teach women to be responsible for their actions, recognize anger signs, use time-outs, understand consequences, learn communication techniques, change thinking patterns, reduce stress, and discontinue using substances (Leisring et al., 2003). These groups differ from those used for men by emphasizing the women's safety, attending to their hierarchy of needs,

attending to potential trauma, educating them about symptoms of stress and depression and healthy releases, emphasizing parenting behaviors, and lessening emphasis on power and control (Leisring et al., 2003).

Compared to their male counterparts, female perpetrators suffer harder consequences from the criminal justice system and society for their acts of aggression (Stalans & Finn, 2006). The National Coalition Against Domestic Violence is available to assist women who have been unjustly accused of IPV (http://www.ncdbw.org/).

Persons With Disabilities and IPV

The Americans with Disabilities Act provides for persons with disabilities to receive the same rights and resources as persons without disabilities; nevertheless, women with disabilities who experience domestic violence are marginalized in society (Barranti & Yuen, 2008). In the 1990s, Margaret Nosek formed the Center for Research on Women with Disabilities (CROWD) and began researching various issues, including IPV (Barranti & Yuen, 2008). In a nationwide survey of 429 women with disabilities and 421 nondisabled women, 62% "of women with disabilities reported physical or sexual abuse victimization at some point in their lifetimes, whereas 52% of the nondisabled women reported such victimization . . . IPV experiences of women with disabilities involved qualitative differences from those of nondisabled women" (Barranti & Yuen, 2008, pp. 118–119).

As compared with nondisabled women, women with disabilities experience abuse for longer periods of time. They were more likely to be victimized by health care providers, caretakers, and attendants (abuses of the helping relationship; Center for Research on Women with Disabilities, 2002).

Despite this victimization, these women's risk factors, needs, and barriers to services are virtually unexplored (Barranti & Yuen, 2008). The very nature of having a disability instills unique psychological and physical barriers to escaping domestic violence, including fears of having medical treatment withheld, being denied personal care, receiving rough handling, and not being allowed to make one's own decisions (Cramer, Gilson, & DePoy, 2003). Types of abuse toward women with disabilities include refusing to provide care, using children as leverage to keep women in an abusive environment, isolating women from support and services, and delaying care (Cramer et al., 2003). Society tends to have negative attitudes to and images of women with disabilities, which may result in their request for help being disbelieved and services being withheld (Cramer et al., 2003). Service delivery systems are ill equipped for these women, who may require wheelchair access, seeing-eye dog assistance, and/or sign language communication (Cramer et al., 2003).

Women with disabilities may excuse abusive behaviors if the perpetrator is their caregiver by considering the acts as a response to the stress of caring for them (Cramer et al., 2003). If they report their caregivers, either they or their perpetrators could be removed from the home, leaving them unable to care for themselves. Without this care, they may be institutionalized, lose the right to make decisions, and lose custody of their children.

Policies, education, and resources are needed to provide the protection, information, and services needed by victims with disabilities. Law enforcement

and the courts require additional training. Social workers need sensitivity to abusive situations in working with persons with disabilities. They need knowledge of resources for transportation, communication (e.g., computer-assisted communication and interpreters), and specialized training if they are to assist these victims effectively.

Culture and IPV

It is incumbent upon professionals to understand the various cultural backgrounds and beliefs of their clients in order to help them achieve maximum well-being (McGee, 1997). The prevalence, rationale, and costs of domestic violence change depending on the individual's ethnicity, personal experiences, and intentions (Malley-Morrison & Hines, 2004). The challenge to social workers and other helping professionals is to act culturally competent in the provision of services to families experiencing domestic violence. This section provides a brief overview of IPV and selected racial and ethnic populations.

Immigrant Women

Immigrant women face unique barriers in seeking escape from domestic violence. In particular, undocumented women (those who are not legal U.S. citizens) may be especially dependent on their male partners/husbands. In such cases abusers can use immigration status to control their victims, threatening deportation. This threat can be especially traumatic for immigrant women whose children were born in America and thus are U.S. citizens; for them, deportation can mean separation from their children (Warrier & Rose 2009). However, through the Violence Against Women Act (VAWA), immigrant women can petition for legal status without the support of their abusive sponsors/husbands; they can even prosecute their abusers (8 U.S.C 204)(a)(1).

Numerous cultural values from the country of origin can affect immigrant women's risk of IPV and their response to it. These can include rigid patriarchal values; the importance of maintaining the family; religious values; the stress of moving to another country; limited English language proficiency; cultural and social isolation; institutionalized racism; and negative U.S. attitudes and policies toward immigrants in general (Warrier & Rose, 2009).

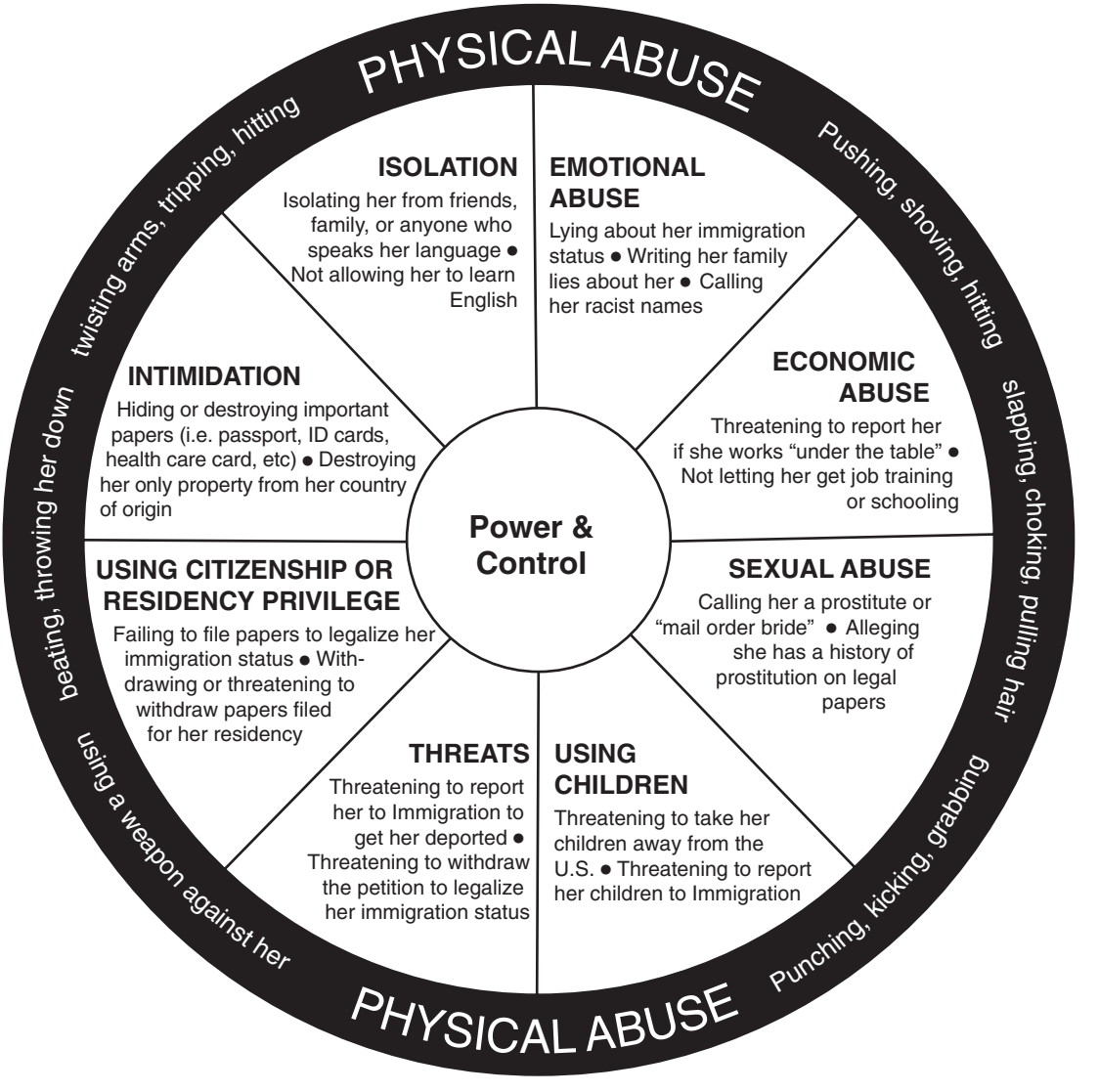
These and other issues are summarized in the power and control wheel for immigrant women (n.d.); see Figure 13.1.

Asian Americans/Native Pacific Islanders

The Asian American and Native Pacific Islander (AANPI) communities comprise a diverse mix of racial and ethnic identities from more than 50 countries. Some studies have found lower rates of intimate partner violence among AANPIs than in other groups (see Table 13.1). Others (Dabby, 2007) suggest that the rates may be higher and that traditional Asian values, such as the emphasis on family unity, may discourage Asian women from disclosing abuse (Tjaden & Thoennes, 2000).

13.1

Power and control wheel for immigrant women.



While IPV among AANPI communities can follow the same dynamics as outlined in Chapter 7, some unique cultural factors may be encountered in this population. Unique examples of physical abuse may include battering by multiple abusers (such as members of the extended family) within the home; intensive surveillance; withholding of necessities (food, hygiene products, medication); "hyperexploitation" of the woman's household labor; and cultural practices such as honor killings, contract killings, and deaths related to dowries or

13.1 Persons Victimized by an Intimate Partner in a Lifetime by Victim Gender, Type of Victimization, and Victim Race

Victim Gender/Type of Victimization	White	African American[d]	Asian/Pacific Islander (API)[c]	American Indian/ Alaska Native (AI/AN)[a]	Mixed Race
Women	*N* = 6,452	*N* = 780	*N* = 133	*N* = 88	*N* = 397
Rape	7.7	7.4	3.8 [b]	15.9	8.1
Physical assault	21.3	26.3	12.8	30.7	27.0
Stalking	4.7	4.2	— [e]	10.2 [b]	6.3
Total victimized	24.8	29.1	15.0	37.5	30.2
Men	*N* = 6,424	N 659	*N* = 165	*N* = 105	*N* = 406
Rape	0.2	0.9 [b]	— [e]	— [e]	— [e]
Physical assault	7.2	10.8	— [e]	11.4	8.6
Stalking	0.6	1.1 [b]	— [e]	— [e]	1.2 [b]
Total victimized	7.5	12.0	3.0 [b]	12.4	9.1

[a] Estimates for American Indian/Alaska Native women are significantly higher than those for White and African American women: Tukey's B, $p \leq 0.05$. [b] Relative standard error exceeds 30%; estimates not included in statistical testing. [c] Estimates for Asian/Pacific Islander women are significantly lower than those for African American, American Indian/ Alaska Native, and mixed-race women: Tukey's B, $p \leq 0.05$. [d] Estimates for African American women are significantly higher than those for White women: Tukey's B, $p \leq 0.05$.
[e] Estimates not calculated on fewer than five victims.
Source: U.S. Department of Justice (2000). Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey, p. 26.

bride prices (Dabby, 2007). Unique examples of emotional abuse may include more rigid gender roles; isolation from family members in the home country; family pressure to stay in the marriage and tolerate the abuse; and silencing the women through the threat of shame and family dishonor that public disclosure of abuse might bring (Dabby, 2007).

For further information, visit the Asian & Pacific Islander Institute on Domestic Violence (http://www.apiahf.org/index.php/programs/domestic-violence.html).

African Americans

Data from the National Violence Against Women survey found that the lifetime prevalence rates of IPV among African Americans was 26.3%, as compared to 22.1% for Whites (Tjaden & Thoennes, 2000), which is not statistically significant. However, data from the National Family Violence Resurvey NFVR show a more pronounced difference in annual incidence rates: 17.4% for African American women, significantly higher than that found for whites (Straus & Gelles, 1986).

Many theorists suggest that social and structural contexts influence the rate of IPV among African Americans. Many African American men live in violent social environments, with high rates of homicide, acquaintance violence, and suicide (Williams, 2008). They suggest that African American communities are particularly vulnerable to higher rates of violence for a variety of reasons, including historical oppression, sexism, racism, and socioeconomic disadvantage (Carrillo & Zarza, 2008).

For more information, see the Institute on Domestic Violence in the African-American Community (http://www.dvinstitute.org/).

Hispanics

Data from the National Violence Against Women survey found that the lifetime prevalence rates of IPV among Hispanics was 21.3%, as compared to 22.1% for Whites (Tjaden & Thoennes, 2000), which is not statistically significant. However, data from the National Family Violence Resurvey found a 17.3% annual incidence rate for Hispanic women, significantly higher than that for Whites (Straus & Gelles, 1986).

Domestic violence among Latino populations must be understood in terms of a legacy of oppressions, including poverty, discrimination, racism, and colonization (Carrillo & Zarza, 2008). In addition, cultural influences, such as traditional patriarchal values and an emphasis on family and community must be considered (Carrillo & Zarza, 2008)

For more information, see the National Latino Alliance for the Elimination of Domestic Violence (http://www.dvalianza.org/).

Native American Populations

The National Violence Against Women survey found that American Indians/Alaska Native women had significantly higher rates of IPV than Whites (Tjaden & Thoennes, 2000). While not much research has been done specifi-

cally with this population, some suggest that historical trauma (unresolved trauma and grief from past incidents), internalized oppression, as well as the loss of traditional beliefs and values, such as spiritual ceremonies, may contribute (Duran, Duran, Woodies, & Woodis, 2007).

Same Gender–Oriented Partner Abuse*

Although empirical studies on domestic violence between opposite-gender partners has steadily increased since the 1970s, similar research on same-gender partners remained virtually nonexistent until the last 20 years (Renzetti, 1992). Relying on empirical data, policies and programs are lacking in their ability to provide protection and services for same-gender individuals experiencing domestic violence, thus creating further social injustices for this oppressed population. Empirical data are needed to provide evidence of these injustices and to dismiss existing myths about this social problem.

Research

In America's homophobic society, researching domestic violence between lesbian and gay male partners is at best challenging as, in their efforts to preclude oppressive forces from gaining information that could be used to further persecute them, these individuals have created a conspiracy of silence about the existence of violence within their homes. This silence results in many of these individuals being double closeted—entombed in their same-gender identity and in their personal pain of abuse.

Findings from existing research reveal many similarities between same-gender and opposite-gender IPV. The prevalence rate of approximately 25% to 35% of all partners experiencing IPV is comparable (Gunther & Jennings, 1999), thus, of the 19 million same-gender couples (Island & Letellier, 1991), about 5.7 million report being either victims or perpetrators of IPV. Also similar are the types of violence reported, including sexual, physical, financial, and emotional abuse (Renzetti, 1992; Merrill & Wolfe, 2000). The spiral of violence is common—the violence increasing in frequency and severity over time (Tully, 1999). Despite the similarities, IPV between lesbian and gay male partners differs in its theoretical underpinnings and is fraught with myths.

Although applicable to opposite-gender partners, the patriarchal theory, with its cultural endowment of domination of men over women, cannot explain the existence of same-gender partner abuse; however, four theoretical approaches are proposed as underlying this phenomenon: (a) personality disorders by Island and Letellier (1991); (b) feminist theory by Renzetti (1996); (c) the social–psychological theory by Merrill (1996); and (d) social–psychological theory as underlying gay male IPV and patriarchal social–psychological the-

*This section is excerpted with permission from "Domestic Violence Between Same Gender Partners: Recent Findings and Future Research," by J. C. McClennen, February 2005. *The Journal of Interpersonal Violence, 20*(2),149–154.

ory by McClennen (1999). More information on these theories is presented in Chapter 7.

Research as to domestic violence between same-gender partners being primarily **mutual battering** is dismissed by a majority of research as a myth (McClennen, Summers, & Vaughan, 2002). However, the continued belief in the existence of mutual battering has contributed to victims being rebuffed by helping professionals, who cannot believe that domestic violence could occur between individuals of the same gender.

Being rebuffed by professionals, same-gender victims' help-seeking behaviors, as supported by recent research, are directed principally toward their friends (McClennen, Summers, & Daley, 2002). Formal sources (attorneys and shelters) are seldom sought, and therapeutic sources (psychologists and social workers) are perceived as lacking in helpfulness. The inability to receive helpful, responsive professional services and protection contributes to victims' maintaining long-term relationships with their perpetrators, as they remain silent about their abuse.

As between opposite-gender partners, the principal correlate attributed to the existence of same-gender partner abuse is power imbalance (Renzetti, 1992). (The strategies same-gender-oriented perpetrators use to control their victims is illustrated in Figure 13.2.) Determining the composition of this imbalance is more challenging than with opposite-gender abuse where, historically, men have been imbued with power over women. For lesbian partners, the correlate of power imbalance has been attributed to the combined factors of perpetrators' lack of communication and social skills; perpetrators' experiencing intergenerational transmission of violence and exhibiting substance abuse and faked illnesses; victims' internalized homophobia; and couples' status differentials (McClennen, Summers, & Daley, 2002). For gay male partners, the factors contributing to power imbalance remain anomalous.

After power imbalance, the major correlates of lesbian IPV are dependency and jealousy (McClennen, Summers, & Daley, 2002). As to gay male IPV, following power imbalance, the major correlates are dependency, jealousy, and substance abuse followed closely by possessiveness and independence (McClennen, Summers, & Vaughan, 2002). Most likely, further studies would provide evidence of perpetrators' lack of communication and social skills as well as intergenerational transmission of violence and HIV as contributing to gay male IPV.

Future Research

Much additional information is needed as to the theoretical underpinnings, myths, and correlates of same-gender partner abuse. Knowledge of the existence, realities, and correlates of IPV between same-gender partners can help professionals to provide protective services, assessing clients' relationships, providing helpful intervention services, and conducting further research into this multifaceted social problem.

Especially scanty is research about children living within households headed by same-gender couples where the adults are experiencing IPV. Also needed is increased education as well as advocacy, policies, programs, and effective assessment and treatment strategies.

13.2

Power and control wheel for lesbian, gay, bisexual and trans relationships.

Same-gender persons are in need of education and advocacy, as many are unaware of the existence let alone the magnitude of lesbian and gay-male domestic violence. Factual information is intended to reduce the stigma of same-gender persons who are experiencing partner abuse and to empower both victims and perpetrators to seek professional assistance. Advocating with same-gender persons, professionals can assist in grass roots and social planning strategies toward ameliorating this social problem.

Social workers, psychologists, medical personnel, law enforcement, clergy, educators, and other professionals working with same-gender persons need education to help them change policies, establish programs, and provide appropriate intervention strategies to serve this population. Policies and laws are needed to give same-gender partners the same rights and protection afforded opposite-gender couples.

Culturally sensitive programs and services are needed for intervention with same-gender couples experiencing domestic violence. Counselors must use assessment tools designed uniquely for same-gender partners. Evaluation is needed to ensure the effectiveness and efficiency of programs and services.

Methodological Innovations

Research studies within the same-gender community require improved methodological approaches. Sample sizes are usually small, and nonprobability techniques are used. Research using large sample sizes and probability techniques would greatly enhance the validity of findings and their generalizability. Numerous national surveys have been conducted on the prevalence of domestic violence. Additional funding is needed to conduct nationwide surveys and research focusing exclusively on same-gender domestic violence.

Participatory qualitative research has been found effective in uniting the researcher and the population being researched into a collaborative effort while studies are under way. This type of research has provided a wealth of information about domestic violence between same-gender partners. Rather than being researched, individuals experiencing this problem become an integral part of the study from designing the data-collection instruments to validating the findings and conclusions.

Summary

When members of at-risk and diverse populations are also victims of domestic violence, they live in multiple-jeopardy (Butler, 1999). In their pursuit of effective advocacy, assessments, and intervention, social workers and other professionals must work toward meeting the needs of these populations with additional knowledge, resources, and cultural competence.

Sharing Stories of Pain, Fear, Shirley Lute Was Freed After 29 Years Behind Bars in Husband's Killing

Gone are the days of humiliation when Shirley Lute's husband forced her to wear a dog collar and bark.

Gone are the beatings, the cigarette burns on her skin, the days he'd tie her up or leave her locked in a cold basement.

(continued)

Lute is 76 now and came to Clayton on Saturday to talk about life as a battered woman. She is using her experience to persuade other women in trouble to get out and get help.

Her husband is long gone, shot then stabbed by Lute's son in 1978.

Shirley Lute spent 29 years behind bars, convicted of murder-for-hire. Prosecutors alleged she offered her son $5,000 from a life insurance policy to kill Melvin Lute. It's a charge she denies. Her son, sentenced to 30 years for the crime, has since recanted his statement that his mother was involved.

But the stories of abuse—not the murder and conviction—are what brought her to the Ethical Society here Saturday. Just six months after being released from prison, Lute cried at the podium, sharing her story with a crowd of about 150 people.

"I hope and pray that all the other women who've been battered can get away, and that all the people who know about it will help," Lute said.

Saturday's forum—entitled, "Why Didn't She Leave?"—was sponsored by the Women's Initiative for Health and Safety. It featured Jane Aiken, a Georgetown University law professor who represented Lute for seven years, and Karen Morrow, a successful Clayton businesswoman who escaped from her abuser before anyone died.

Organizers gave the forum its name because, they say, people who ask that question fail to understand the complicated problems that women trapped in abusive relationships face.

"Folks need to imagine how it would be to leave your house, your children, uproot everything in your life, tonight," said Colleen Coble, executive director of the Missouri Coalition Against Domestic Violence and Sexual Assault.

Coble said people who suspect abuse have an obligation to help, though it needs to be done delicately so the batterer doesn't find out. Even passing a note about a crisis hot line could bring trouble if the abuser inspects his wife's purse.

"If you have the slightest inkling that something wrong is going on, we have to have the courage to step up and speak," Coble said. "That's our job. That's how this changes. There is no tolerance."

The emergence of shelters and other assistance programs that give battered women a place to turn has actually lowered the number of men being killed, Coble said.

Yet Aiken said three women a day in this country are killed by an intimate partner, and the chances that an abused woman will be killed increase greatly if she tries to leave or has left.

Morrow, who runs a high-end clothing boutique in Clayton, said she went to work with bruises. She didn't leave her husband at first because, she says, she thought she could fix things.

"I wish the few who did know would've been more forceful, took me in, shook me and sought help," said Morrow, 57, who eventually called an abuse hot line and filed a restraining order against her husband.

Saturday was Lute's first time speaking to a group since her release, and the audience gave her a standing ovation.

(continued)

Lute was one of 11 women championed by the Missouri Battered Women's Clemency Coalition, a group that includes professors and students at the state's four law schools. She won clemency in 2004 from then-Gov. Bob Holden, though her supporters had to take the legal fight to the state Supreme Court, which ordered her release.

Her voice quivering, Lute told the crowd how her husband of two years tormented her in the trailer they shared and the grocery they ran in Middle Grove, Mo.

She said she tried to leave her husband three times. Each time, he stopped her, and his threats escalated. On her final attempt, he had disabled the car, so she fled on foot in heavy snow. He was waiting for her on a rural road nearby and locked her in the basement for two days.

Looking back, Lute said, "I grew up thinking being battered is what life was." When she was 9, her alcoholic father sold her for a bottle of wine to a wino who molested her, she said.

Lute now lives in an efficiency apartment at a senior citizens complex in Columbia, Mo. Its kitchen is larger than her prison cell was. She works part time at a food pantry, earning $6.50 an hour. She collects $540 a month in Social Security.

It beats prison work, where she got 50 cents an hour as a seamstress, hemming men's underwear.

Her goal is to work at Wal-Mart in Columbia. "I would make an excellent greeter," she says happily. She applied, but the store hasn't invited her back for an interview. She thinks it has something to do with her felony conviction. (Bell, 2007)

—Reprinted from the November 4, 2007, issue of the *St. Louis Post-Dispatch* (MO).

Discussion Questions

1. There is no information presented as who actually killed Melvin Lute or how he was killed. A quick review of the Internet gives some ideas as to the allegations and occurrences. What do you think would have been your opinion if you heard testimony of this killing 30 years ago? Give your rationale taking into consideration Shirley's childhood, the years the couple was married, the children, and any other issues you think relevant.
2. What do you think the outcome would have been from the courtroom if Melvin had killed Shirley with a gun? How would it be the same? How would it be different?

Key Terms

At-risk populations
Cultural competence
Cultural sensitivity
Mutual battering
Social and economic injustices
Social exclusion
Temporary Assistance to Needy Families (TANF)

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Introduction to Elder Abuse

14

Love of Cats Leaves Homes, Life a Shambles

For Lovella Sparwasser, known to authorities as the Cat Lady, taking care of her felines means everything.

She doesn't notice the smell, says Lovella Sparwasser, also known as the Cat Lady to authorities.

"Cat odor doesn't bother me," says Sparwasser, a tiny, 77-year-old woman with long grayish-white hair that she sweeps up in front, Gibson girl style.

In the heat of the day, she stands outside a condemned house in the 700 block of Lemay Ferry Road, where she rented a room more than three years ago.

(continued)

Sparwasser holds a bag of Church's fried chicken, what's left of her lunch. It's for the kitties, she explains, the stray cats that live around the house.

Her newest place of residence is the Applegate Retirement Home, less than a mile away. She says she was taken there the previous week by a St. Louis police officer after she had been evicted from a friend's apartment in the city and 17 of her cats had been taken away.

The previous day, St. Louis County authorities tried to catch up with Sparwasser at the house she owns in the 9500 block of Gentry Avenue in Lemay. She was kicked out of the house a year ago because of its squalid condition, but neighbors frequently spotted her coming back to feed her cats.

For Sparwasser, taking care of her cats means everything to her. As she puts it: "What's so great about life if you can't have a few things to love?"

Like her previous home, the house on Gentry was a nightmare, neighbors say. Last week, St. Louis County paid an environmental cleanup firm more than $4,000 to clean it of cat urine and feces and to remove flea-infested carpets and dozens of bags of old garbage in the basement. In the three years she lived there, Sparwasser's neighbors say, she never had garbage service.

Since 1993, county authorities have either evicted Sparwasser or cited her for living in squalor at four houses. In addition to her home on Gentry, Sparwasser was evicted from a house she inherited from her parents in the 3700 block of Edwards Avenue in Mehlville.

County municipal court records show 10 separate housing-code violation cases against Sparwasser since 1993. Eight cases involved the house on Edwards, which was sold. Two current cases involve the house on Gentry.

A county health official says Sparwasser also lived for a while at a friend's home in the 100 block of Brilliant Lane, which also was cited for code violations.

Judy Tucker, a next-door neighbor to Sparwasser on Gentry, says she can't understand why authorities let Sparwasser move from house to house. She says she has seen Sparwasser walking the neighborhood while wearing a blouse with cat urine on the back of it.

Tucker says she went into Sparwasser's house on a cold day last winter to help with a broken water pipe. She stayed less than five minutes and gagged on her way out, the smell was so bad. She says there were "bags and bags and bags" of trash in the basement.

"It looks like the court system would see that this lady is not capable of taking care of herself," says Tucker. "They can go in and take people's kids away from them, but they can't seem to do anything with her."

Tucker says she worries about Sparwasser, especially because she's elderly and likes to wander the neighborhood at night.

"I just feel so sorry for her," says Tucker. "We're not wanting her thrown out of her house; it's just that she won't maintain it."

But there's only so much the courts can do, says Joe O'Connell of the county's Neighborhood Preservation office. The office has been aware of Sparwasser for years.

(continued)

"If someone doesn't want to cooperate or if you don't have a family member that can commit you," there isn't a lot that can be done, says O'Connell.

Records show that Sparwasser spent a day in jail in March 1999 after at least eight cases against her were combined. But everyone involved with the case agrees that jail isn't the answer for a 77-year-old woman who needs help.

It's difficult to help someone who doesn't want the help, says Mike Nickel, regional manager of Missouri's Division of Senior Services. The state agency protects the elderly and disabled adults from abuse and neglect.

A person living in squalor may have mental problems, but it's usually not the type of problem that gets someone declared incompetent, says Nickel. The state offers mental health services, but the person doesn't have to accept the services.

In fact, animal hoarders or collectors typically don't think they have a problem, experts say. Animal collecting is an illness that started getting attention and study about 10 to 15 years ago.

People who turn a love of pets into an obsession often can't see that collecting large numbers of animals is harmful. Some experts liken the obsession to someone who has a substance abuse problem. Animal collectors are preoccupied with their addiction, will neglect themselves to pursue it and often will claim persecution or alibis for their behavior.

Some experts believe that people become animal collectors after a psychological trauma—a divorce or the death of a loved one. Hoarders often feel a need to control every aspect of existence for the animals in their custody. Like family

Sparwasser says she always has loved animals. She says she was married once, but she and her husband split up after about 15 years. She has a grown son who lives in Jefferson County, but they aren't close, she says.

Sparwasser talks about her cats as if they were her family. She reminisces about Tammy, a cat who was one of her favorites. "It was just like as if I gave birth to her," she says.

After her cats were taken away from her in the city, Sparwasser says she went to the St. Louis pound to see them. One was a cat named Frankie, who she says turned and meowed at her when she called his name.

Authorities say Sparwasser has lived at a retirement home before, but she didn't stay long. Sparwasser says she doesn't really like living in a group surrounding. "I like to be alone," she says. "Too many people make me nervous."

She complains that her current residence discourages her from going out at night. She likes to walk the neighborhood, looking for stray cats. And she's angry that authorities threw away her clothes from the house on Gentry.

"I don't care if they smell; people can just stay away," she said. "I don't like people that much anyway." (Little, 2003)

—Reprinted from the July 10, 2003, issue of the *St. Louis Post-Dispatch* (MO).

Helping older persons who are being abused (or, in the case of Mrs. Sparwasser, are self-neglecting) is challenging. The paucity of research on elder abuse that can guide decision making is well documented; this social problem is much less studied than either child abuse or intimate partner violence (IPV). Much needs to be accomplished to understand it and to protect older persons against it (Erlingsson, 2007; Selwood, Cooper, & Livingston, 2007). This chapter provides a foundation for understanding the types and prevalence of elder abuse. Several theories and legislative policies that are particularly applicable to this type of maltreatment are also discussed.

Elder Abuse Defined

Elders are defined as adults 60 years and older. According to Tatara (as cited in Daly & Jogerst, 2006, p. 20), "Federal definitions of elder abuse, neglect, and exploitation can be found in the **Older Americans Act** (42 USC § 3002). All states have enacted laws that address domestic and institutional elder mistreatment." Each state has its own definition of what is considered elder mistreatment (Daly & Jogerst, 2006). Forty-nine states and the District of Columbia have **Adult Protective Services** (APS)–related statutes defining elder mistreatment (Daly & Jogerst, 2006).

Elder abuse (also known as **elder mistreatment**) can be defined as

> *(a) intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm. (Bonnie & Wallace, 2003, p. 39)*

However, this definition has been criticized for not including inadvertent or unintended acts, and it also omits any reference to self-neglect (an elder's failure to satisfy his or her own needs). Finally, the inclusion of *vulnerable* may imply that abuse to able-bodied elders is not included (Nerenberg, 2008). No one official definition exists, and professionals take different perspectives of the definition for their own professional purposes (Brammer & Biggs, 1998; Daly & Jogerst, 2006).

Elder abuse can occur in any setting, whether in the person's own home or in an institutional setting such as a retirement facility or nursing home. In an institutional setting, harm may be inflicted by other residents or personnel (Loue, 2001, pp. 160–161).

This has tremendous implications for public policy and community services. If elder maltreatment is considered endemic to the home, policies and funding will address abusive individuals; however, if abusive behaviors are viewed as occurring principally in institutions, policies will focus on quality of care. A collaborative effort is needed to create a uniform definition of elder abuse and to determine the underlying causes and theories, characteristics of victims and perpetrators, and effective practices on the basis of which policies and funding can be established to protect older persons from maltreatment.

Types of Elder Abuse

According to many common definitions, elder abuse can occur in seven different forms: physical, emotional or psychological, sexual, financial or other material exploitation, neglect, abandonment, or self-neglect (Cohen, Levin, Gagin, & Friedman, 2007; Fulmer, 2008; Thompson & Priest, 2005).

Physical Abuse

Physical abuse is defined as

> *The use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse. (National Center on Elder Abuse, n.d.)*

Signs of physical abuse may include (but are not limited to): bruises, black eyes, welts, lacerations, fractures, wounds, sprains, broken eyeglasses, signs of being restrained, findings of overdose or under-use of prescribed medications, and an elder's report of being hit or mistreated (National Center on Elder Abuse, n.d.).

Emotional or Psychological Abuse

Emotional or psychological abuse is defined as

> *The infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment"; and enforced social isolation are examples of emotional/psychological abuse. (National Center on Elder Abuse, n.d.)*

Signs of emotional abuse may include (but are not limited to) being emotionally upset, withdrawn, noncommunicative, exhibiting unusual behavior (i.e., biting or rocking), or reporting emotional abuse. (National Center on Elder Abuse, n.d.).

Sexual Abuse

Sexual abuse is defined as

> *Non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual*

> *abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing. (National Center on Elder Abuse, n.d.)*

Signs of sexual abuse may include (but are not limited to) bruises around the breasts or genital area, unexplained sexually transmitted infections, unexplained vaginal or anal bleeding, bloody or torn underclothing, and an elder's report of sexual abuse (National Center on Elder Abuse, n.d.),

Financial or Material Exploitation

Financial or material exploitation is defined as

> *The illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney. (National Center on Elder Abuse, n.d.)*

It should be noted that various forms of controlling an elder's property, if properly authorized, are legal. **Conservatorship** is the right to control another's finances on his or her behalf (often when the other person is incapacitated or unable to make decisions for him or herself). **Power of attorney** is the right to make business or legal decisions on another's behalf for either a specific issue or specific period of time. (One type common in elder law is a **health care power of attorney,** which allows one to make health care decisions on behalf of another.)

Signs of financial exploitation include (but are not limited to): sudden changes in bank account or banking practices, unauthorized withdrawal of funds, abrupt changes in a will or other financial documents, substandard care or unpaid bills despite financial means, discovery of forged signatures on financial documents or titles, a new relationship in the elder's life, the sudden appearance of relatives in the elder's life, sudden, unexplained transfer of assets to a family member or other person, and an elder's report of financial exploitation (National Center on Elder Abuse, n.d.).

Neglect

Neglect is defined as

> *The refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an*

implied or agreed-upon responsibility to an elder. (National Center on Elder Abuse, n.d.)

Signs of neglect include but are not limited to dehydration, malnutrition, poor hygiene, untreated health problems, unsafe or hazardous living arrangements, unsanitary or unclean conditions, or an elder's report of being neglected (National Center on Elder Abuse, n.d.).

Abandonment

Abandonment is defined as "the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder" (National Center on Elder Abuse, n.d.).

Typical signs include but are not limited to an elder being abandoned at a hospital, nursing facility, or other health care institution; or at a shopping center or other public location (National Center on Elder Abuse, n.d.).

Self-Neglect

Self-neglect is characterized as

The behavior of an elderly person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice. (National Center on Elder Abuse, n.d.)

The signs of self-neglect are similar to those of neglect by another (National Center on Elder Abuse, n.d.). Self-neglect is the most commonly occurring and misunderstood type of elder mistreatment and receives the most fragmented response by health care and other professionals (Lauder, Anderson, & Barclay, 2005).

Prevalence of Elder Abuse

Few national sources of data on elder abuse exist. However, the 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older (Teaster et al., 2006) found that in 2003, over half a million (565,747) reports of elder abuse and neglect were made to Adult Protective Services (APS)—a 19.7% increase from the previous survey, conducted in 2000. Of the reported cases, 461,135 were investigated and 191,908 were substantiated (Teaster et al., 2006).

The majority (89.3%) of victims were abused in domestic settings where they lived alone or with other persons, while 6.2% were abused in long-term

care settings or other domiciles (hotels or assisted living facilities; Teaster et al., 2006).

The sources of reported cases of elder abuse were as follows:

- 17% family members
- 16.6% social services workers
- 8% friends and neighbors
- 6.3% self
- 5.5% long-term care facilities
- 5.3% law enforcement
- 4.7% nurses
- 3.8% anonymous
- 2.9% home health staff
- 1.4% physicians
- 22.8% other (Teaster et al., 2006)

The types of abuse reported to APS were:

- Self-neglect (26.7%)
- Caregiver abuse (23.7%)
- Financial exploitation (20.8%)
- Emotional/psychological/verbal abuse (13.9%)
- Physical abuse (12.5%)
- Sexual abuse (0.7%)
- Other reasons (2%; Teaster et al., 2006)

The principal perpetrators were:

- Females (52.7%)
- Persons under 60 years of age (75.1%)
- Adult children (32.6%) or other family members (21.5%; Teaster et al., 2006)

The victims principally were:

- Female (65.7%)
- Persons age 80 years and older (42.8%)
- White (77.1%)
- African American (21.2%)
- American Indian and Alaskan Native (0.6%)
- Asian (0.5%)
- Native Hawaiian and Pacific Islander (0.2%)
- Other (0.2%; Teaster et al., 2006)

Although the findings do indicate the race of the victims, the prevalence of elder abuse among culturally diverse populations lacks sufficient research findings to draw many conclusions (Cooper, Selwood, & Livingston, 2008; Laumann, Leitsch, & Waite, 2008).

Some researchers estimate that five times as many new incidents of abuse and neglect go unreported as those that are reported and substantiated (Tatara et al., 1998). Reasons that elders may not report the abuse include fear of increased abuse or retaliation, social stigma, or the belief that reporting will not improve the situation. Professionals may not report because of lack of protection for whistleblowers, ignorance about how or when to report, or fears of violating the privacy of the victim and/or the family (Brandl et al., 2006).

Theories of Elder Abuse

Various theories underlying elder maltreatment are predominant in the literature, and each differs according to causation attributed to the maltreatment (Bonnie & Wallace, 2003; Whittaker, 1995). The **pathology theory** assumes that the abusers' intraindividual problems require mental health treatment. The **theory of transgenerational violence** attributes abuse to learned behavior in which the adult abuser was mistreated as a child and now is retaliating with similar behaviors. The **social exchange theory** suggests that all social interactions between persons involve rewards and punishments. In the case of elder abuse, the victim is dependent on the abuser for care (a reward); however, the abuser does not feel that the victim reciprocates with equal rewards and thus withholds care or "punishes" the victim. The **situational model** suggests that caregiver stress and excessive demands may cause the caregiver to ultimately lash out; however, this theory has been disproved by research. The **feminist theory** places responsibility on sociocultural attitudes toward the elderly and lack of resources within the community. Each theory results in different assessment procedures and intervention strategies.

Elder abuse can be approached using an **applied ecological framework** (Schiamberg & Gans, 2000) that combines the human ecological perspective with the life course perspective, thus addressing the various systems (individuals, families, groups, organizations, and communities) as they influence and are influenced by human behavior over time. The applied ecological perspective incorporates a bifocal view (one of the elder and one of the abusing adult) to assist in determining the risk factors to elderly persons' healthy lifestyle. Using this theory, the focal system is considered to be the individual. Other systems potentially adding risk factors are the microsystem (i.e., the family), the mezzosystem (relationships among family members), and the macrosystem (the organizational and community ideological values and norms). The chronosystem addresses the influence of changes and continuities on the development of aging persons in relationship to other systems over time. Using this theoretical approach, social workers can approximate the extent of risk factors for an elder to be abused by considering the interactions among the various systems, the events that took place during the elder's life, and the elder's present functioning in the broader environment.

Ageism and Elder Abuse

In 1969, Robert Butler coined the term **ageism**, associating it with other forms of discrimination, such as racism and sexism, that result in a group of individuals

being shunned from mainstream society. Ageism is the "ultimate prejudice, the last discrimination, the cruelest rejection" (Palmore, 1990, p. 2).

Common stereotypes against the elderly suggest that they are sick, impotent, senile, useless, lonely, poor, and depressed, despite the fact that many elderly persons are intelligent, active, socially engaged, and productive members of society. Ageism may be an underlying factor in elder abuse, and it may explain why so little attention, and resources, have historically been paid to understanding and combating elder abuse (Brandl et al., 2006).

Key Legislation for Elders and Elder Abuse

"In 1965, the Older Americans Act was passed and established programs and offered services and opportunities for older Americans" (Daly & Jogerst, 2006, p. 21). The Older Americans Act (OAA) established the Administration on Aging (AOA) within the Department of Health, Education and Welfare and called for the creation of state units on aging. Area Agencies on Aging were established to ensure that services were carried out in accordance with legislation.

> *In 1974, Congress mandated a protective services program for adults under Title XX of the Social Security Act (Administration on Aging, 2002). This APS program provides a "system of preventive, supportive, and surrogate services for the elderly living in the community to enable them to maintain independent living and avoid abuse and exploitation." (Regan, 1978, as cited in Daly & Jogerst, 2006, p. 21)*

The Social Security Act has continually been amended and in 1980 the Central Registry Unit was initiated nationwide (Wolf, 2000).

In 1987, the Omnibus Budget Reconciliation Act provided for nursing home reform in the area of nurse aide training, survey and certification procedures (Historical Evolution of Programs for Older Americans, n.d.). However, since the largest proportion of abuse takes place in homes, and much remained to be done for protecting elders in domestic settings. By 1989, every state had some type of adult protection program, and 42 states had enacted legislation mandating the reporting of elder abuse (Loue, 2001). In 1992, reauthorization of the Older Americans Act placed increased focus on caregivers and protection of elder rights (Administration on Aging, n.d.).

Web sites for various resources related to elder abuse are provided in Appendix B.

Summary

Elder abuse is an underreported, understudied, and underserved crime which impacts millions of older Americans and their families. It can take many forms, including physical, emotional, sexual, and financial. Social workers are obligated to advocate on behalf of these elders to preserve their dignity and the profession's integrity.

Abuse of Elderly Could Rise as U.S. Population Ages; 80 Percent of Cases Go Unreported Today, Report Says

Advocates for older victims urge the public to pay attention to the issue; one study says 500,000 were abused or neglected in 1996.

In May 1997, 92-year-old Joseph Schroer wandered into a restaurant near Greenville, Ill., and told workers there that his wife of eight years had just locked him out of his home. He also told them he had been physically abused.

The workers called police. Eventually, Victoria Schroer, 55, was arrested and sentenced to 60 days in jail and four months of electronic monitoring. The judge also forbade her from setting foot on her husband's property or from having regular contact with elderly people.

The Schroer case is unusual for several reasons: It got the public's attention at the time; it involved the legal system and criminal charges; and the elderly victim was a man. Most cases of abuse of the elderly go unreported and unnoticed by the general public, said Kayla Vaughan, an area advocate for abuse victims.

A national study estimates that only one in five elderly abuse cases is reported. That means that at least half a million older persons in domestic settings were abused or neglected, or had experienced self-neglect—that is, for whatever reason had not taken care of themselves—during 1996, the only year analyzed. As America's population ages, elderly abuse may increase. That means more services are needed to help the elderly and to combat domestic violence among older people, states the National Elder Abuse Study, released to Congress in September.

Most elderly domestic violence goes unrecognized because it can't compete with prevailing perceptions that domestic abuse involves young women being physically attacked, Vaughan said.

Yet abuse among the elderly is just as real and just as painful, she said. And solutions are often more difficult to find or even nonexistent, because of the victim's age, physical and emotional condition, and economic status.

One of the oldest clients to seek help from Lasting Solutions was an 88-year-old woman who had suffered through a 25-year marriage to a man who treated her as a servant, refused to allow her to talk to her relatives and restricted her access to money—he wouldn't even give her enough to buy a newspaper, Vaughan said.

"Women in their 60s, 70s or 80s grew up in a different time," Vaughan explained.

"In a time when it was common not to work outside the home. They know that life is not OK, but they have a hard time seeing what options they have."

(continued)

Fear of financial insecurity leaves them few options, advocates say.

The economic reality for some victims is a choice between abuse and poverty. Never having worked outside the home, many elderly victims lack job skills. They usually don't have their own pension or retirement account and have little or nothing built up in social security benefits. They are reliant upon the abuser for their financial survival.

O'Brien told of a woman who claimed 44 years of psychological abuse. She was in her 70s when she finally decided to get an order of protection against her husband, and he was ordered out of their house. He threatened to burn the house down, O'Brien said, but the victim never considered a divorce because she was dependent upon his retirement income.

On the other hand, Vaughan told about an octogenarian who divorced her husband because of emotional and psychological abuse; she left her house, got an apartment in the city, and has started her own business as a seamstress.

Some elderly victims fear other repercussions from agency intervention.

They may be afraid of making courthouse appearances. Or they are afraid of being forced out of their homes and placed into nursing homes, or having decision-making power taken from them and placed with a third party.

Elderly victims "have so many fears about who will take care of them in the future, they would rather try to work things out," Tofall said.

"Women who grew up with strong religious beliefs that carried them through tough times often turn again to religion and prayer. . . . And many victims don't want to leave their homes. It's all they have ever known or wanted to know. They are totally unprepared for a communal-living situation that shelters provide."

Most of the victims were women, and the study found that physically handicapped victims were more likely than others to suffer abuse.

Psychological abuse by spouses seems to generate the most complaints of elderly abuse. . . . But physical abuse still occurs. Vaughan told of a patient at St. Mary's Health Center in Richmond Heights. The 62-year-old woman was using a wheelchair because her spouse had broken both her legs.

Abuse by adult children is one of the most difficult scenarios, said Oelbaum and Vaughan, often because the abuser is addicted to drugs and alcohol. The victims blame themselves because they raised their abusive children, who may be in their 40s and 50s, and they take responsibility for the actions of their offspring.

There is also often a fear of family estrangement. O'Brien cited the case of a woman in her 60s whose family turned against her when she went to court against her husband because they felt she was "airing the family linen."

"Adult children won't admit any abuse took place in the home," O'Brien said, "or they take the position: 'Mom or Dad, you put up with the situation for so long, why are you going public now?'" (Lhotka, 1999)

—Reprinted from the May 16, 1999, issue of the *St. Louis Post-Dispatch* (MO).

Discussion Questions

1. The article at the beginning of the chapter and the one at the end report different stories about elder abuse. What types of maltreatment are evident in each of them?
2. Which theories could explain the abuse presented in each story?
3. What services could be provided to Mrs. Sparwasser (in the first story) to improve conditions for her?
4. Where is the line between the ethical codes of "self-determination" and protecting people from harm? Apply this to the Sparwasser situation.
5. What steps can be taken to encourage older persons to report abuse?
6. What do you think about the explanation given in the second article as to the reasons abused women stay in their homes?
7. What policies are needed, if any, to protect elders from mistreatment?

Key Terms

Adult Protective Services
Ageism
Applied ecological framework
Conservatorship
Elder abuse
Elder mistreatment
Feminist theory
Health care power of attorney
Older Americans Act
Pathology theory
Power of attorney
Self-neglect
Situational model
Social exchange theory
Theory of transgenerational violence

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Identifying and Investigating Elder Abuse

15

Belleville Woman Is Charged in Mother's Death

A woman from Belleville was charged Tuesday with criminal neglect after police found her 90-year-old mother dead and signs that the older woman had been chewed on by a dog in their apartment.

Karen F. Vickers, 65, of the first block of Orchard Drive, was charged with two counts of criminal neglect of an elderly person. She is being held in the St. Clair County jail in lieu of $100,000 bail.

Belleville Police Sgt. Don Sax said that on Sept. 6 an officer was stopped by a newspaper carrier at 5:20 A.M. and told that a woman had fallen in a parking lot. The carrier assisted the officer in getting the woman, who was intoxicated, to her feet and inside her apartment.

(continued)

> The officer saw the woman's mother, Bernice Vickers, 90, in a bed in the living room with an oxygen hose. Her leg had been partially eaten by the family's poodle, authorities said. Bernice Vickers had been neglected for some time and had been dead for several hours, police said. (Hollinshed, 2007)
>
> —Reprinted from the September 12, 2007, issue of the *St. Louis Post-Dispatch* (MO).

Social workers are among the most likely professionals (along with health care providers) to detect **elder abuse** and, with rare exceptions, are mandated to report it (Choi & Mayer, 2000). Knowledge and awareness of risk factors can help to identify persons being abused and situations where abuse is more likely to occur. Risk assessments can be easily and quickly applied and reports to Adult Protective Services (APS) can be made.

APS workers investigate complaints and attempt to protect at-risk older adults. Among the unique barriers in investigating cases of elder abuse is that these clients need protection; however, they are adults who can reject the offer of protection. Collaboration is required among social workers, members of the criminal justice system, health care professionals, and a community of persons to reduce risk factors for the elderly.

Risk Factors

Multiple factors contribute to the level of risk for being a victim of elder abuse, including gender, health, age, quality of spousal relationship, history of abuse, and coping abilities.

Surveys suggest that men are more likely to suffer elder abuse; however, more women than men are reported for abuse and neglect. This may be because female victims experience greater physical and emotional harm (Nerenberg, 2008). Older men learn to isolate, which results in depression, self-neglect, and suicide, especially for men in bereavement over loss of their spouse (Kosberg, 1998). Women also tend to live longer then men, which results in increased frailty and responsibility on caregivers. All these factors increase their risk of abuse (Pittaway, 1995).

Because of the close relationship between domestic violence and elder abuse, abusive marital relationships are more highly associated with elder abuse. Female victims of marital abuse have varied reasons for not receiving help, including that they are not aware of services, cannot use the available services, fear rejection by the family and church, and anticipate placement in a nursing home (Beaulaurier, Seff, Newman, & Dunlop, 2007). More information about the older battered woman is presented in Chapter 13.

The theory of intergenerational violence suggests that a history of abuse increases the probability of elder abuse: that adults who were abused as children commit abuse as an act of retaliation against their parent or parents (McGarry & Simpson, 2009).

Caregivers' poor coping abilities result in their tendency to become abusive, especially if they abuse substances (Cohen, Lewis, Gagin, & Friedman, 2007). When caregivers abuse substances, they become more volatile and more likely to mistreat the dependent older person.

Assessing Elder Abuse

Indicators of abuse and neglect can be physical, environmental, social, and/or behavioral on the part of older persons or their family members. The signs and symptoms of various types of elder abuse are discussed in Chapter 14.

The following are some recommendations for questioning older persons about potentially abusive situations: (a) use open-ended yet direct questions about the mistreatment; (b) use assessment tools such as the Abbreviated Mental Test (Dyer & Rowe, 1999); (c) keep well-documented, behaviorally oriented records; (d) be sensitive to victims; (e) interview the victim and perpetrator separately; (f) do not be authoritative to suspected perpetrators, as they will be more reticent to respond if they are approached aggressively; and (g) offer victims options and resources (Bergeron, 2000; Welfel, Danzinger, & Santoro, 2000).

Attention should be paid to the elder's basic health care needs and whether or not they are being met appropriately. Possible signs of elder abuse include that the elder seems to need a physician but does not seem to be receiving care; that health care explanations from the elder and/or caregiver are contradictory or implausible; and that the caregiver is "doctor hopping" (visiting multiple doctors to prevent anyone from tracking the elder's true condition; Bomba, 2006).

Elders often require assistance to obtain and administer their medications and other supplies, such as dentures, glasses, hearing aids, and medical equipment. Elders who remain at home may need help in maintaining their utilities (including proper wiring, heat, and running water), maintaining a safe and clean environment, and having clean clothing available. If these needs are not met, there may be cause for concern.

Certain behavioral signs may be cause for concern. If elders do not want a visitor to leave or do not want to leave when they are visiting another, they may either be abused and afraid to be alone with the abuser or may be neglected and starved for human companionship. Elders exhibiting unjustified fear or excessive crying may be maltreated (Bomba, 2006). Questioning is required in these situations.

It is important to note that certain behaviors that may seem "eccentric" may or may not be signs of elder abuse. For example, the National Center for Elder Abuse's definition of self-neglect "excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice."

Risk assessments assist in determining the lethality of the situation in which the elder person is living in the present and for the future. Risk assessments are categorized as either (a) **screening tools** that identify abused elders and their present risk for abuse or as (b) **assessment instruments** that determine future risk of abuse (Wolf, 2000).

Many of these instruments are designed and implemented for APS workers to use throughout their care planning (Dyer et al., 1999). Abbreviated **biopsychosocial interviews** can serve this purpose; they collect information including marriage length and stability, previous relationships, caregiver burden, coping mechanisms, alcohol consumption, and intergenerational living arrangements (Marshall, Benton, & Brazier, 2000). Helpful instruments include the Indicators of Abuse Screen (IOA), which lists 27 indicators of abuse and provides information on intrapersonal and interpersonal problems as well as social supports (Reis & Nahmiash, 1997). The expanded IOA (E-IOA), which expands the IOA to include a semistructured interview, is available (Cohen, Halevi-Levin, Gagin, & Friedman, 2006). The Risk of Elder Abuse in the Home (REAH) instrument is a measure of strain and family changes that may heighten the risk of abuse (Nerenberg, 2008).

Multidisciplinary teams are recommended for assisting in the risk assessment and care planning for elders. These teams usually consist of social workers, pharmacists, physicians, nurses, law enforcement officers, substance abuse counselors, occupational therapists, psychiatrists, gerontologists, and mental health professionals (Dyer et al., 1999; Dyer & Goins, 2000). The combination of the expertise of these professionals with appropriate assessment tools result in the most beneficial, holistic risk assessment for victims.

Reporting Elder Abuse

All 50 states have legislation to protect elders from abuse. Although mandatory reporting assists in the investigatory process, only 44 states and the District of Columbia specify mandatory reporters (for a list of states, including hotline numbers and websites, see Appendix B). The six states not regulating mandatory reporters are Colorado, New Jersey, New York, North Dakota, South Dakota, and Wisconsin (Daly, Jogerst, Brinig, & Dawson, 2003, p. 6).

The criteria as to which professionals are mandated reporters differ among states. Some states have an exact list of professionals who must act as reporters, some say "any person," and others have a list plus the "any person" addition. Among those states that do specify mandated reporters, social workers are commonly named.

Some states have exceptions to the mandatory reporting statute, which holds harmless certain professionals engaged in confidential relationships with elderly clients. States tend to exempt clergymen, practitioners of Christian Science or other religious healers, attorneys, social workers working for alleged perpetrators' attorneys, and physicians. States entitle them to determine whether a report is in the elder person's best interest.

When elderly persons do not want their mistreatment reported, mandated social workers find themselves in an ethical dilemma. They are legally mandated to report the abuse, yet they are ethically bound to respect the self-determination of their clients. In such cases, social workers can consult with peers, supervisors, or other members of the health care team if applicable (Nerenberg, 2008). Working with the client in an empowerment model—involving the client in the process, providing information and referrals, and offering rather than mandating services—can be helpful (Brandl et al., 2007).

The lack of uniformity among states in their definition, criteria for reporting, use of mandated reporters, and other administrative and policy issues causes concern and problems in the efforts of social workers to protect elders from abuse (Daly et al., 2003). The onus of the responsibility lies with professionals for knowing state policies, such as whether they qualify and under what circumstances they qualify as mandated reporters (Roby & Sullivan, 2000).

Adult Protective Services

The **Older Americans Act** (OAA) was passed in 1965 and increased awareness of the need to protect older citizens. By 1974, all states had passed legislation to provide protective services to adults. **Adult Protective Services** (APS) is responsible for investigating reports on mistreatment to elderly persons living in private residences. APS is under the auspices of the Department of Social Services and is staffed primarily by social workers. In the 1980s, the National Association of Adult Protective Services Administrators (NAAPSA) was formed to offer support and exchange ideas among these agencies.

In 1978, an amendment to OAA mandated establishment of the **long-term-care ombudsman** program, which is responsible for investigating complaints on abuse to elderly persons residing in institutions. These programs tend to be located in state units such as the Office on Aging.

The principles guiding APS, in accordance with the report from the U.S. Congress (1981), include the client's right to self-determination, use of least restrictive alternatives, maintaining family units, using community-based services rather than institutions, avoiding blame, and providing the best available services (Otto, 2000). Although policies vary greatly among states, many follow the basic model for APS programs. Responsibilities assumed by APS programs are to receive reports, conduct investigations, evaluate risks to clients, address clients' capacities, develop and implement case plans, counsel clients, arrange for services, and monitor service delivery (Otto, 2000).

Investigations

A case begins when an APS worker receives a call about possible abuse. Cases are categorized as (a) immediate, (b) 48-hour response, and (c) less severe response. No matter which category it falls into, every case will include a face-to-face visit with the elderly person to determine the validity of the report. If it is considered valid, a case may be given a "pedigree," which is a number used to track it throughout the system.

APS workers first triage cases for immediacy of needed response. If a case is considered an emergency, they may enter the elder's residence without a court order, at which time they are usually accompanied by law enforcement. If the elderly person needs protection from another person, an *ex parte protective order* can be obtained immediately and the suspected perpetrator can be removed temporarily from the home until a full hearing is held before a judge, which occurs in about 30 days.

In less severe cases, the APS worker can enter the home by obtaining either the permission of the elder or, if deemed necessary, a search warrant from the

court. The court can authorize restraining orders to be served on perpetrators, who must then stay away from the elderly person and his or her resources (Roby & Sullivan, 2000).

APS workers provide assessments and interventions with older adults, who are often experiencing a multitude of problems. To best serve elderly clients, workers' expertise must be broad, including (a) knowledge of medical problems, diseases, disabling conditions, and uses of commonly prescribed medications and their interactions; (b) recognition of medical emergencies and the ability to protect themselves from infectious diseases; and (c) a keen awareness of the service delivery systems of law enforcement, criminal justice system, medical and social services, and legal assistance. Workers must be able to assess and intervene with abusive and neglectful acts; conditions requiring medical, substance abuse, financial, mental health, and other types of services; and the aging processes (Bergeron, 2000; Otto, Castano, & Marlatt, 2002).

The services provided by APS workers are categorized into two groups: (a) legal services and (b) general health or social services. Legal services include working with police, crisis intervention assistance, investigation, guardianship proceedings, protection orders, court work, and miscellaneous legal assistance. General health and social services include case management (e.g., case coordination, periodic monitoring, homemaker services, medical care, therapy, or home health assistance); nutritional assistance (e.g., meals on wheels); income assistance; supervision, reassurance and counseling; housing, relocation, or transportation services; socializing and recreation services; job training; and institutional placement (Roby & Sullivan, 2000, p. 35).

Investigative procedures with mistreated elders differ from investigations in other types of family violence (i.e., child abuse and intimate partner violence). In child abuse, authorities can act as **parens patriae,** meaning they can take action as if they were the parents of the victim and "in the best interest" of the child. In elder abuse, this is not an option, because adults have the right to self-determination. They have the right to make their own choices as long as they understand the consequences. Intervention in elder abuse cases typically includes an evaluation of the elder's decision-making capacity, to be sure that he or she is able to make rational decisions and communicate them, understand the consequences, and act in his or her own best interest (Nerenberg, 2008).

The court procedures also differ. In child abuse cases, authorities have a specialized court system to assist in family crises; this is not the case in elder abuse. Victims must enter civil and criminal courts to access protection. These more formal settings and procedures are intimidating to elderly people and tend to deter them from taking action toward protecting themselves (Bergeron, 2000; Payne, Appel, & Kim-Appel, 2008).

Elder abuse also differs from intimate partner violence, where victims have access to shelters to escape the violence; this is not the case with the elderly. Shelters may not be physically accessible or tolerable to older persons. Also, many shelters are secretive and highly monitored to protect their client's safety; this may not be attractive to older persons, who prefer more independence (Bergeron, 2000; Payne, 2008).

Investigating suspected sexual abuse to elders is particularly difficult for APS workers; however, in these situations, workers must respond immediately. Assistance is to be sought from supervisors and other appropriate professionals (e.g., law enforcement) if resistance is met from the elder or the family. Interviewing clients in this situation requires particular skill. The victims may wish to protect the perpetrator. The perpetrator may try to intimidate the worker. Special training is required in the use of rape kits, the investigation of harmful sexual practices, and various other areas particular to sexual abuse cases. The most highly trained of APS workers are called upon in these cases (Chihowski & Hughes, 2008).

APS workers learn a wealth of information such as local resources for the elderly, working with the police, obtaining medical care for victims, and working with community-based service providers. Additional training is required on various issues such as means for protecting themselves and issues related to domestic violence such as intervening with a perpetrator, obtaining mental health services, and coordinating services with the criminal justice system (Payne, 2008). Among the tools that assist APS in their investigative procedures are risk assessments.

Criminal Justice System

Adult Protective Services (APS) carries out its responsibilities principally in conjunction with law enforcement, the criminal justice system, and the long-term care ombudsman (LTCO). Law enforcement assures protection for all parties involved. The criminal justice system provides court orders and final decisions in the welfare of citizens. The LTCO has access to residential facilities and, if the perpetrator is an employee or administrator of a facility, can obtain specific records (Roby & Sullivan, 2000).

Unlike child abuse and domestic violence situations, no specialized court procedures are available for mistreated elderly. Victims, who become "wards" of the court for protection, must use the civil and criminal court system. The court can appoint a guardian ad litem and a legal counselor to represent the best interests of the ward. The guardian ad litem investigates the entire situation around the complaint and the life of the person and makes a recommendation to the court as to the best course of action. The legal counselor represents the elderly person within the court system (Roby & Sullivan, 2000).

The court can also appoint a "visitor" or a public guardian to assist in assuring elderly person's rights are represented. Visitors are not attorneys; however, they represent the best interests of elderly persons within the court process. Public guardians coordinate services and educate elderly persons and their families about the court procedures.

These various representatives advocate on behalf of elderly persons and are especially needed in financial matters. When the court considers elderly persons to be incapacitated, the judge may remove their power over their financial resources. At a guardianship hearing, the elders' resources are placed in **conservatorship,** which grants other adults permission to assume

management of these financial resources. Once elders are considered incapacitated, the burden of proof for assuming conservatorship is fairly low and tends to make **guardianship hearings** "rubber stamping" ceremonies (Roby & Sullivan, 2000, p. 40). Avoiding elder persons' financial exploitation is the responsibility of the guardian ad litem and other professionals appointed by the court.

In cases where a perpetrator has been charged with a criminal offense, the perpetrator has the right to due process and to legal counsel. Perpetrators must be notified of any hearings and the charges made against them. Protective orders that can remove alleged perpetrators from their homes cannot be issued without a court hearing, which gives them an opportunity to present their side of the issue.

Along with the verdict, the court can determine parties responsible for costs of services for attorneys, institutions, and other parties. If elderly persons are able to pay, they are often ordered to cover the costs. They can use insurance benefits and other third-party payments such as Medicare and Medicaid. At times, the court may order the perpetrator to pay for some charges (Roby & Sullivan, 2000).

Throughout all these procedures, APS remains the gatekeeper of service delivery for mistreated elderly. Other representatives (guardian ad litem, visitors, attorneys) for the elderly alleviate any conflict of interest that the APS workers may experience. As representatives assist with legal issues—including requests to the court for subpoenas, protection orders, and reimbursement charges—APS makes regular updates to the court until the case is closed. The various players in the criminal justice system help ensure that the most appropriate decision is made for all parties concerned.

Summary

Being aware of risk factors, having the ability to identify abused elderly, and reporting suspected cases is the responsibility of all professionals. Once potential elder abuse has been identified, mandated reporters need to contact their local Adult Protective Services (APS) office.

Investigation policies and procedures are under the auspices of APS. Since the 1980s, the National Association of Adult Protective Services Administrators (NAAPSA) have communicated to assist in improving the service delivery system to mistreated elderly persons and have basic principles and a model in place to guide agencies and their workers. APS workers must investigate complaints and provide the most appropriate, least restrictive service delivery system to elderly clients. Their responsibilities must be coordinated with other systems throughout the community most specially law enforcement, long-term-care ombudsman (LTCO), and the criminal justice system.

APS works with abused elders to overcome the unique barriers to receiving help, which includes the lack of specialized court procedures. If older persons can access the courts, the court can appoint a guardian ad litem, legal counselors, visitors, and public guardians to advocate on their behalf. APS workers remain the principal parties for assuring the safety of elderly persons.

Two Competing Wills Are Disputed in Court Under Review: An Elderly Couple Promised Their Assets to People Who Had Befriended Them

Leonard and Helen Whertwine worked hard and saved their money. They took road trips on their Harley-Davidson motorcycle, all decked out with extra lights and trim.

He was a welder for [a] truck repair shop near downtown . . . she a supervisor at [a] central bakery. They had no children.

Financially secure, they enjoyed the quiet life in a shaded ranch home in the country. As their health declined, they needed help. A few local acquaintances obliged.

Now, relatives and a county official suspect the couple were being exploited.

The Whertwines' assets are the subject of a dispute in the Bollinger County Courthouse, where a judge is reviewing two competing wills the couple signed at different times last year.

One document promises their estate to a woman who lives nearby. The other names two men from the other end of the county. All three befriended the couple in this decade.

Helen Whertwine died on March 5 at age 83. Her husband, 87, is under the care of a full-time, in-home assistant. His doctor says he suffers from dementia, and a judge in Marble Hill declared him incapacitated.

The financial stakes are significant—court documents show Leonard Whertwine's assets at $338,000, mostly in real estate and bank accounts. But Bollinger County Public Administrator Larry Welker, court-appointed guardian since January, said he's also interested in the whereabouts of some guns and jewelry that the Whertwines supposedly gave away.

"This was a real mess when we got involved," said Welker, an elected official. "My main goal is to get Leonard cared for and keep him in his house. That, and get those wills thrown out."

Welker believes the estate probably should go to Leonard Whertwine's two nieces and nephew. Whertwine's in-laws include a brother and sister of the late Helen Whertwine who filed the original suit in October, seeking to have the first will thrown out.

"Older people, especially those without children, can become vulnerable to anyone who offers to be helpful, no matter what that person's motivation might be," said Gilchrist, [a university professor of law], who has no role in the case.

On Aug. 23, the Whertwines signed wills naming Suzanne M. Morse . . . as sole beneficiary of their assets and their dog, Toggo, after they both die. They already had granted Morse power of attorney on June 14 last year to make financial decisions.

(continued)

Morse, 35, testified in court in March that she met the couple six years ago and began doing chores for them.

"I mowed the grass, I grocery-shopped, I put on her brace. I done everything for them," said Morse in testimony recorded by the court. "I didn't want money. I just loved them."

One trip she took them on was to a lawyer's office . . . to sign the documents. Morse said her sister's husband knows the lawyer. Of the arrangement, she said, "Leonard and (Helen) wanted that done."

In an interview June 7, Morse said, "Folks are trying to get me in so much trouble, and all I ever did was try to help. I worked my butt off for six years."

Less than four months after the Whertwines willed their assets to Morse, they signed new wills naming as beneficiaries Wilmer A. Stroup of near Puxico and John R. Heffner of Marble Hill. The men met the Whertwines while doing some work at their home.

Stroup, 52, testified in April that he had "known Len seven, six years." Stroup said the Whertwines wanted him to take some guns and jewelry, some of which he sold. "I did what they told me to do. That's all anyone can do," he said.

Heffner, 72, followed Stroup in the witness chair, testifying that the couple wanted to void the first will. Heffner said last week that Whertwine insisted on the new will naming him and Stroup.

"It's a crying shame that people can't leave what they want to whomever they want, but I sure don't want to take advantage of anyone," Heffner said.

Both men told the court they had no objection to having the will voided, but disagreed on what should happen to the estate. Stroup said it "should go to Suzie Morse. I've been up there and saw her helping them." Heffner said it "should go to the family."

Mattie Hlabdallat, the live-in assistant at the Whertwine house, said she signed the Stroup-Heffner will as a witness at the couple's request.

She said last week that the two men came to the house Dec. 12 "and talked them into it. They stood there by (Helen Whertwine's) bed it seemed for hours. She said she was tired of signing papers when she didn't know what she was signing. It was sickening to watch."

Scott Fetterhoff of Marble Hill, whose law office prepared the Stroup-Heffner will, said he could not comment because of attorney-client privilege. But he said, "If I meet with people, and I don't believe they are competent, I do not execute a will for them."

In testimony, Morse named Thomas David Swindle, now an associate circuit judge in Doniphan, as the lawyer she took the Whertwines to see. Swindle could not be reached.

Les Waggoner of Warsaw, Missouri, the brother of Helen Whertwine, said they were from a big family . . . Waggoner said he and another sister, Alice Hansen of Warsaw, filed suit out of fear that the Whertwines couldn't handle their financial affairs anymore and because they were suspicious of the will naming Morse.

(continued)

"We wanted the Whertwines to be able to retain their assets. The money needs to be for his health, while he's still with us," said Waggoner, a retired loan officer.

As for the estate, he said, "It should go to family before it goes to anyone else."

Leonard Whertwine's nephew, Gary L. Johnson, 59, of Villa Ridge, has a lawyer monitoring the court case. His cousins live in the South. He said he was grateful that Waggoner filed suit and that Welker is pursuing the case.

As for the eventual resolution, Johnson said, "I just want my uncle to be cared for and have a long life." (O'Neil, 2007)

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Discussion Questions

1. What types of elder abuse are evident in the two stories in this chapter?
2. Who was in a position to help Bernice Vickers in the first story? Who was in a position to help the Whertwines? What could have been done?
3. Should anyone in the Whertwine case be charged? With what crimes?
4. Who do you think should be the beneficiary of the Whertwine's estate? Why?
5. What might Adult Protective Services have done to help the Vickers?
6. If you were to have a multidisciplinary team to assess Bernice Vickers, who would you have on the team?

Key Terms

Adult Protective Services (APS)
Assessment instruments
Biopsychosocial interviews
Conservatorship
Elder abuse
Guardianship hearings
Long-term-care ombudsman
Multidisciplinary teams
Older Americans Act
Parens patriae
Risk assessments
Screening tools

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Elder Abuse Assessment and Intervention

16

Man Accused of Assaulting His Ailing Elderly Mother

A man said to be upset with his elderly mother and her worsening health is accused of punching her and holding a pillow over the face of the 88-year-old woman.

John R. Noble, 61, who lives . . . with his mother and sister, was charged Wednesday with first-degree elder abuse, a Class A felony, according to the charges.

Helen L. Noble, who suffers from Alzheimer's and had returned home from hospice care Saturday, was taken to a hospital with body bruises and cuts to her face, county police spokeswoman Tracy Panus said.

(continued)

> Police said John Noble admitted that he had lost his temper and attacked his mother but could not explain why, other than he had drunk some beer that night.
>
> "I guess he was just frustrated about having to take care of her," Panus said. "He was just angry."
>
> As John Noble was preparing his mother for bed, police charged, he punched her three times in the back, then held a pillow over her face.
>
> Helen Noble's daughter, Patricia Sprick, stopped her brother from suffocating their mother, according to court documents, and called police.
>
> John Noble told police he loved his mother and had taken care of her for years, according to the arrest warrant. (O'Connell, 2007)
>
> —Reprinted from the July 25, 2007, issue of the *St. Louis Post-Dispatch* (MO).

Being a **caregiver** to an older adult is demanding and at times overwhelming (Lopez, Crespo, & Zarit, 2007). However, as the number of older Americans increases, so will the need for others to care for them. In 1990, 1 out of 8 persons in the U.S. population was 65 years of age or older; by 2050, that ratio will change to 1 out of 5 persons (Loue, 2001). The likelihood of elder abuse will increase as well.

Although concern is growing, public awareness and response to elder abuse lags far behind attitudes toward child abuse and intimate partner violence (Moye & Marson, 2007). Because of the barriers to identifying and assessing abused and neglected older adults, it is estimated that only 10% of cases are actually reported (Cohen, Halevi-Levin, Gagin, & Friedman, 2006).

Chapter 15 discussed the use of risk assessments by Adult Protective Services (APS) to determine the lethality of a situation in which an elder is living. This chapter looks at assessments used by social workers, clinicians, physicians, and other professionals who interact with elders on a regular basis. These tools can help professionals gather information from elder persons and/or their caregivers. Instruments include screening tools, which can help determine imminent safety issues, and assessment instruments, which determine longer-term safety issues. Following the assessment, interventions are implemented to help families resolve problems and find the most acceptable arrangements for the elderly person (Desmarais & Reeves, 2007).

Assessment

In the assessment process, professionals gather sufficient data to understand the relevant family dynamics and establish a plan to address the issue. Social workers, health care workers, and clinicians are among the frontline professions able to assess for potential mistreatment (Fulmer, Guadagno, Dyer, & Conolly, 2004; Schofield & Mishra, 2003). Older adults may require services from all of these professionals to assess and treat various physical, emotional, and

financial issues. All professionals involved need a heightened level of awareness about the signs and symptoms of elder maltreatment. Professionals should hone their skills for ascertaining the etiology of injuries and symptoms, maintain a value-neutral approach for eliciting cooperation from potential perpetrators, use empowerment strategies, and advocate for victims (Lithwick, Beaulieu, Gravel, & Straka, 2000).

Elders face numerous barriers to reporting abusive or neglectful behaviors. Victimized older adults may believe that their abuse is a "family problem" that must be kept silent and away from friends and outsiders (Desmarais & Reeves, 2007). Victims feel shame for their abuse and fear people will judge them. They fear their abuser's retaliation, either through physical or emotional abuse. Many victims are socially isolated, so that they are not aware of being abused and of possible means for seeking assistance (Schofield & Mishra, 2003).

Additionally, elderly persons encounter physical and cognitive challenges that threaten their well-being and may confuse the assessment process. Some studies show that elder abuse victims are more likely to have dementia than nonvictims; it may be violent or dementia-related behavior that increases the risk of abuse (Nerenberg, 2008). However, some signs of abuse may be misinterpreted as signs of dementia, or a person with dementia who complains of abuse may not be believed.

Capacity Assessment

To overcome these barriers, professionals conduct a **capacity assessment,** which is a separate field of study within legal, clinical, and behavioral research. The capacity assessment requires professionals to integrate data on many issues of persons' lives including their potential neuropsychiatric illness, living situation, financial management, treatment consent, and testamentary capacity (i.e., the "coercion of a vulnerable adult to do something that will benefit the coercer" [Moye & Marson, 2007, p. 8]). A critical area in the process is the identification of cognitive and behavioral markers of the person's diminished capacity to make competent decisions as to their care.

Capacity assessments are particularly helpful in identifying elders who are suffering from self-neglect, which accounts for 37% of substantiated reports to Adult Protective Services (APS; Naik, Lai, Kunik, & Dyer, 2008, p. 26). Self-neglecting adults, because of physical or mental limitations, are unable to obtain the necessities of life (food, clothing), maintain healthy living conditions, and/or manage their financial affairs.

Capacity assessments can determine elders' capacity for self-care and self-protection (SC&P), their ability to make decisions that are in their best interest, and their ability to carry out the decisions either by themselves or with the assistance of caregivers. Domains of self-care include (a) personal needs and hygiene, such as activities for daily living (ADLs) including bathing, ambulation in the home, and toileting; (b) condition of the home environment, such as avoidance of safety risks; (c) activities for independent living such as laundry and meal preparation; (d) medical self-care such as medication adherence; and (e) financial affairs and estate matters, such as managing monthly bills (Naik et al., 2008). The inability to care for themselves may result in elders requiring the services of a long-term care facility, which can be difficult for elders and

their families and is a decision that requires a comprehensive assessment prior to its occurrence (Taylor & Donnelly, 2006).

Assessment Instruments

The comprehensive assessment will involve further data gathering. Various assessment instruments are available to help identify the presence of elder mistreatment (EM; Fulmer et al., 2004) and determine risk factors associated with mistreatment, such as client characteristics (e.g., age, gender, and confusion), abuser factors (e.g., limitations, skills, alcoholism, and fatigue), environmental factors (e.g., health violations, structural soundness of victim's home, and home location), and historical abuse (e.g., previous abuse; Anetzberger et al., 2000).

Instruments vary widely, and most have some limitations (such as measuring only a certain type of abuse). Some are qualitative, others quantitative, and still others combine quantitative and qualitative aspects (Fulmer et al., 2004). They vary in complexity from a one-page tool to an intensive instrument and require anywhere from a few minutes to hours for completion. Some are user-friendly, enabling anyone to use them, while others require a trained administrator. Used in conjunction with professional judgment, instruments can help determine the most appropriate course of intervention on behalf of mistreated elders.

These screening and assessments instruments include:

- The Minimum Data Set for Home Care (MDS-HC; Shugarman, Fries, Wolf, & Morris, 2003): A tool for identifying older people at risk for mistreatment that measures their cognitive patterns (short-term memory problems), disease diagnosis, physical functioning (activities of daily living [ADLs], hygiene, dressing, locomotion), behavioral problems (abusive or provocative behaviors, physically, verbally, and socially inappropriate behaviors, alcohol abuse), and social functioning/support (residing with others, socially isolated, conflicts with family).
- The Indicators of Abuse (IOA; Reis & Nahmiash, 1998): A 22-item tool for discriminating abuse from nonabuse cases.
- The Elder Abuse Screening Test (EAST; Wolf, 2000): A 15-item tool to screen for physical abuse and neglect.
- The Vulnerability to Abuse Screening Scale (VASS; Schofield & Mishra, 2003): A 12-item self-report on the four factors of vulnerability, dependence, dejection, and coercion.
- The Principles of Assessment and Management of Elder Abuse Tool (Bomba, 2006): A one-page tool for assessing elder abuse.

Caregiver Assessment

Family caregivers make up "the backbone of long-term-care workforce" (Wolff & Kasper, 2006, p. 344). As elders become increasingly debilitated, they may move in with their families, instead of being placed in long term–care facilities. The economic value of family care provided to older persons is estimated to be in the billions of dollars (Dubble, 2006).

Females make up the majority of caregivers, and most are middle aged and employed. Spouses are the most common caregivers, followed by children (Wolff & Kasper, 2006).

Caregivers suffer physically, emotionally, and financially. They may injure themselves while bathing or lifting the elder. Their hours are long and demanding. Many are caring for an elder in addition to children, and they also go to work. They may need to cut down their hours at work, thus reducing their income. Medicare and Medicaid do not cover the expenses of medicine, health care, day care, and other financial demands.

The systemic relationship between the elder and the caregiver results in emotional and physiological exchanges affecting both parties and the entire family. Instruments such as the Dyadic Relationship Scale can help to identify areas of concern (Sebern & Whitlatch, 2007). Attending to all individuals, with special consideration for the elder and the caregiver, is crucial in assessing the likelihood of abuse and providing appropriate interventions.

Intervention

Social workers, law enforcement, and health care providers work collaboratively to provide appropriate interventions for elder maltreatment.

The lead professional role in intervention is partly dependent on the type of maltreatment involved (Wylie, Tutty, Braun, & Jesso, 2006). Physical abuse may require intervention by the criminal justice system, with support and treatment from health care professionals. Financial and material exploitation may require response by civil authorities. Self-neglect cases call for a social services response.

Sexual violence presents a challenge for professionals trying to intervene because so little is known about it (Burgess & Morgenbesser, 2005). The convergence of ageism, sexism, and vulnerability has contributed to the lack of attention given to this issue. Among the barriers to addressing this problem is victims' reluctance to report, professionals' delaying in reporting, and the health care system's failing to identify.

Collaboration among professionals is needed to address sexual violence as well as all types of elder abuse.

Paternalism Versus Autonomy

Although social workers are mandated reporters of elder abuse, victims do not always want the abuse reported, which presents an ethical dilemma. This dilemma involves an array of social work values, in particular the ideological debate between protecting clients (which may be interpreted as paternalism) and honoring their **self-determination** (autonomy). Victims require and deserve protection and safety from abuse; they also deserve autonomy over the actions that influence their lives (Dubble, 2006; Linzer, 2004).

This type of ethical dilemma arises in various scenarios. One example is the self-neglecting client who refuses services even though her living situation endangers her. Another scenario is the maltreated client who refuses to press charges because he fears for the abuser's arrest; the abuser may be the

caregiver. If the social worker involves the criminal justice system, police and court professionals must respond according to their legal mandates (Wylie et al., 2006). These responses may be viewed as paternalistic and involve interventions done "to" versus "with" victims and their families.

The dilemma of protection versus self-determination is overly simplified if viewed as a dichotomous decision. Social workers need to balance the various principles within the NASW Code of Ethics (Linzer, 2004; Moye & Marson, 2007). Among these principles are respect for the dignity and worth of people and valuing individuals' right to self-determine unless they pose a risk to themselves or others (Code #1.2), avoiding abandonment of clients (Code #1.16), seeking interdisciplinary collaboration (Code #2.03), consulting with others when this is in the best interest of clients (Code #2.05), and making referrals when other expertise is needed (Code #2.06). Social workers are required to consider ethical dilemma and apply critical thinking in making decisions about their clients' lives and the lives of other individuals influenced by their clients.

Whatever interventions social workers select, they must be flexible to meet the needs of the particular situation and client. Victims need a voice in the process and consideration of their involved family members and caregivers. Interventions should include a clear definition of the maltreatment, including identification of risk factors and other assessment criteria. Goals should focus on the problems that will reduce the risk factors, and goal priorities are dependent upon the reduction of the most harmful consequences that could occur (Lithwick et al., 2000).

Social workers are advised to begin the intervention with a pragmatic and eclectic approach that accommodates the victim's competencies and infuses empowerment. At a conceptual level, social workers are to assume a "value-neutral approach" (Lithwick et al., 2000, p. 98) that recognizes conflict as a normal part of human relationships.

Although "zero tolerance" of mistreatment is the ideal, anticipation of this end is not necessarily realistic. The correct decision as to the most effective intervention requires balancing respect for the rights of all the individuals in the decision-making process. Effective interventions reduce risk factors and at the same time empower victims and address the needs of perpetrators, particularly when the perpetrators are caregivers.

Treatment Strategies

Families requiring help with elders are often in a crisis situation based partly on fears of elders or stress on caregivers (Taylor & Donnelly, 2006). Crisis intervention strategies are based on Roberts's ***Seven-Stage Crisis Intervention Model*** (Roberts, 1996). This model is based on self-determinations and engagement of clients. The stages include the following: (a) assess for life-threatening danger, (b) establish an emotional connection with the person in crisis, (c) identify major problems in priority order, (d) use verbal and nonverbal counseling skills, (e) identify alternative coping strategies, (f) develop and implement a service plan, and (g) follow up.

Treatment may require a blend of individual therapy, family therapy, and relationship counseling. Helpful strategies include behavioral skills training, cognitive restructuring, and emotional control (Brownell & Abelman, 1998; Thompson & Priest, 2005). In focusing on victims, clinicians may begin by ad-

dressing depression, sadness, shame, and guilt while stressing victims' strengths and survival skills. Other helpful strategies include positive reminiscence for enhancing compassion and attachment between victims and caregivers. (For more on reminiscence, see Kunz & Soltys, 2007.)

Three types of therapies have proven effectiveness for intervening with mistreated elders by reducing fear, stress, and anxiety (Fraser, 2006). **Cognitive behavioral therapy** (CBT) can help change distorted thinking as well as reduce anger and depression; however, this type of therapy is not effective for individuals with cognitive impairment. **Person-centered therapy** (PCT) assists with increasing victims' low self-esteem, facilitating their autonomy, and producing empowerment. **Cognitive analytic therapy** (CAT) focuses on collaboration between mistreated elders and social workers. Because CAT is time-limited, it limits dependency and works well for survivors of abuse.

Beyond such treatments, other services may be needed by abused elders and their families (Nerenberg, 2006). Emergency shelters that are accessible to older persons might preclude elders being further victimized. Individual and group counseling could help alleviate depression, increase self-esteem, and assist in problem solving. Legal assistance would help in filing orders of protection and suing for civil recoveries. Mental health assessment would determine the ability of elders to meet their basic needs and check their mental health status. Case managers would perform assessments, conduct consultations, and write case plans. Other support services would include money management, adult day centers, and friendly visitors.

Professionals are needed to help elders with their guardianship, especially given the gravity of this legal action and the scarcity of information about its processing (Nerenberg, 2006). A court order granting guardianship of an elder to another person gives that other person complete authority over the life of the elder. Elders need protection from individuals who would gain guardianship for the purpose of exploiting them for financial gain. Although this legal process is needed for elders who are unable to speak competently on their own behalf, it is one requiring stricter regulation to protect elders.

Elders' needs extend into long term–care settings, where they are particularly vulnerable to abuse. Approximately, 1.6 million people are in 17,000 licensed nursing homes (Hawes, 2002, p. 1). Characteristics of these elders, the environment, and existing policies increase the probability of abusive behaviors. Elderly persons in these settings experience chronic illness, limited functioning, and dependency on others. Institutional settings tend to have standardized services treating all residents as a homogeneous population, are more concerned with accountability to the government than they are with the residents' concerns, and follow the medical model of efficiency versus caring about residents' self-sufficiency. The prevention of abuse and neglect in residential long-term settings requires increasing the numbers of staff, reducing staff burnout (caused by minimum wages and long hours), and increasing personnel training (Hawes, Phillips, Rose, Holan, & Sherman, 2003; Wood & Stephens, 2003).

Caregiver Interventions

Caregivers require support and validation for their efforts in caring for elders. Through participation in mutual help groups, they realize they are not alone in

their efforts and can learn various strategies for their assumed tasks. Formal counseling, either alone or in groups, can provide necessary support. Day care centers and home care services can provide respite services. Although stress management can be helpful, services directed toward caregiving are more effective. The problems involved in giving care to an elder member of the family is a concern of the entire family and requires intervention for all members (Lopez et al., 2007).

Elder abuse is becoming recognized as a social problem on an international basis—recognition which is long overdue (Brownell & Podnicks, 2005). The International Network for the Prevention of Elder Abuse (INPEA) is a nongovernmental organization (NGO) organized by the United Nations to increase public awareness and knowledge and to promote education and training. International interest is based on the "Silver Tsunami" (p. 188) arriving in 2025, when people aged 60 and over will outnumber people under age 15 years. Selective interventions are to be guided by global principles of dignity, choice, freedom, safety, and least intrusiveness.

Summary

Despite their prevalence, elder abuse and neglect remain grossly underreported. Social workers and health care professionals are in prime positions to routinely assess for maltreatment. Assessments should include assessment tools that assist in professional decision making. Crisis assessments will be required in various instances. Caregivers also require inclusion in the assessment process in recognition of their stressful yet lifesaving responsibilities.

Information on effective interventions is severely lacking, although certain treatment strategies have shown effectiveness. APS workers and other social workers need to use their professional judgment in balancing victims' protection with their right to self-determination. Further research is required into effective programs to prevent and treat elder abuse.

Woman, 72, Found in Home With Corpse

Police went to the home of an elderly St. Charles couple with a court order to take them to a hospital. They found a woman living amid filth and a decomposing corpse.

Officers who forced their way into the home Monday afternoon were overwhelmed by stench, said Cpl. Ron Bextermueller. He said they found the body of Charles Pyatt, 75, in an "advanced state of decomposition" in the living room of the home.

Betty Pyatt, 72, had peeked out the window but refused requests to open the door, police said. Court records describe Betty Pyatt as suffering from dementia and possibly psychosis.

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Charles Pyatt had heart surgery about five months ago. He showed signs of dementia, was blind and a diabetic. Officials feared he was not taking his medications. A social worker with the Missouri Division of Aging last saw him alive on June 27.

On Monday, St. Charles County Circuit Judge Ellsworth Cundiff had granted temporary protective custody of the couple to county Public Administrator Deborah Lanham.

On June 21, a neighbor made an anonymous complaint to the city code-enforcement office about a "severe roach problem" at the couple's white frame house. The caller said roaches were crawling on the windows and driveway and said the Pyatts refused to answer the door, city officials said.

A concerned neighbor also called the Division of Aging abuse and neglect hot line on June 25, said Dr. Linda Allen, deputy director of the division.

"In this case, nobody would have caught it if there hadn't been a bug problem," Allen said.

John Benisch, community service director for St. Charles, visited the home on June 26. He said he noticed a stench when Betty Pyatt opened the front door. He asked to speak with her husband, and Charles Pyatt met him in the garage. Roaches were crawling on the walls and floors of the garage, he said.

Benisch said he sought a search warrant from a municipal judge to condemn the property and notified the Division of Aging. In a report, Benisch said the couple was cited for six code violations in 1998.

Benisch said that after the citation, a pesticide company sprayed the home and a cleaning crew 'cleared out' the house and returned it to a "habitable condition." The couple was also ordered to have the home regularly sprayed for roaches.

On June 27, the Division of Aging social worker went to the home and reported that the couple was living in "isolation, filth, vermin, squalor and confusion." The social worker's report says Charles Pyatt tried to operate the air conditioning by using the garage door switch. It says Betty Pyatt, whose birthday is in September, listed the birthday as having been only a few weeks ago.

The couple refused care from a neighbor and family members.

The Division of Aging sent its report on Friday to the public administrator's office, asking that it seek temporary guardianship. That's the process when family members will not or are unable to take custody, said Allen, the deputy director.

Allen said that the Pyatts' case is not unusual. Social workers responding to hot line calls will often find an elderly person dead or close to it, she said. That's because so much time can go by before anyone checks on them.

"I think we all have these individuals in our neighborhoods who are considered to be sweet little old people. And because they never come out of their house and bother anybody, no one pays attention to them . . .," she said. "But they are actually these nice little old people holed up in their houses depressed, not eating and basically wasting away."

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Allen said people are more apt to report abuse and neglect of children, but not elderly people. Because they are adults, people think their situation is none of their business, Allen said. Or they think they have family members or friends who would be aware of any problems.

"These are our parents and maybe us in 40 years. We, as communities, have to take responsibility for our neighbors," by reporting suspicions to the state's adult abuse hot line at 1-800-392-0210, Allen said. "If the community doesn't step forward and help us, we won't be able to reach everyone we need to reach." (Munz, 2001).

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Discussion Questions

1. Imagine you are the Adult Protective Services (APS) social worker called to help this woman.
   a. What would be the first thing you would do upon receiving the referral from the police?
   b. What type of assessment instruments, if any, would you use?
2. What is your opinion as to the action taken by John Benisch, the community service director?
3. What is your opinion of the social worker? What would you have done differently, if anything?
4. The health department, criminal justice system, and APS are involved. Is anyone else likely to be involved in this situation? Who else should be called in to the assessment and/or intervention process for Mrs. Pyatt?

Key Terms

Capacity assessment
Caregiver
Cognitive analytic therapy
Cognitive behavioral therapy
Person-centered therapy
Self-determination
Seven-stage crisis intervention model

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Prevention of Family Violence

17

Parenting Groups Offer Free Fun for Families

When Donna Guevara first became pregnant, she considered giving her daughter up for adoption.

She already loved the unborn baby and wanted to be a mother. But she worried that generations of child abuse in her family would continue.

Still, Guevara wasn't convinced that child-abuse-prevention classes were for her. She attended her first support group, when she was seven months pregnant, with some hesitation.

Fast-forward 18 years and Guevara can't say enough good things about the Circle of Parents support groups.

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The education and support meetings taught Guevara techniques for when parenting three children ages 5 to 18 gets frustrating, gave her strong friendships with other moms, and helped her break the generations-long cycle of child abuse.

"When you get frustrated, you just don't know what to do, and these classes help you figure that out," the Spotsylvania County mom said. "The groups help everybody figure out how to deal with anxieties, frustrations and everyday parenting issues."

She eventually led the groups . . . But when Guevara talks about how much the support groups help, she finds many people still don't know they exist.

Representatives from more than a dozen regional agencies spend most of the year planning the event, to get the word out about their services for area families. They make up the Coalition for a Community Without Violence.

All say that most families don't know about many preventive services the groups offer. The event features tables with information on crime victims' rights, child abuse, sexual assault and domestic violence.

The eighth annual Family Fun Day will offer a moon bounce, miniature horses, a helicopter, games, lunch and music. Everything is free.

"This will cost not one penny. It's awesome," Guevara said. "This will give parents an outing, to do something fun with their kids and not have to worry about money, especially in these times." (Umble, 2009)

—Reprinted from the April 25, 2009, issue of the *Free Lance Star* (Fredericksburg, VA).

Group Seeks Guys to Help Counter Domestic Abuse—Movement Against Violence in the Home Expands Focus to Prevention

John Capuano was a bit nervous as 70 boys from the junior class filled the bleachers at Bayless High School. He was about to talk to them about sexism, masculinity and patriarchy—tough subjects for a group of teenage boys. Standing on the gym floor, he had 20 minutes to give his spiel.

Capuano, 30, an educator in domestic violence prevention, has created a program called Guys Group, and he's trying to convince school counselors to let him start a club in their schools.

His group is part of a fledgling effort locally, and a growing one nationally, to push men and boys to face domestic violence—not just those who are abusive, but all males.

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Bayless High was the first to let Capuano give a talk recently.

"Do you ever talk about how you perpetuate the violence? How you've been sexist? How you've been disrespectful to women?" Capuano told the boys.

Someone once asked him those questions, he explained. "It hit me right here," he said, tapping his chest.

The talk was met with some confusion.

"What are we going to be talking about?" one student asked toward the end.

Capuano was asking them to take a leap of faith, to meet with him once a week for the next couple of months.

St. Louis is finding its way in this shift in the 30-year-old domestic violence movement—a shift from creating a safety net for victims to prevention. And men and boys, advocates say, need to be drawn into the discussion.

Programs that already work with men who've been abusive, such as RAVEN, want to join the move to bring the message to a larger audience but face some hurdles as the economy causes a financial squeeze.

The aim of the new focus is to encourage men and boys to create a culture that does not tolerate violence against women and challenges social norms about manhood.

"We realize that if we don't work with men and engage men, the problem will never go away," said Juan Carlos Arean of the Family Violence Prevention Fund. The group recently started national awareness programs such as Coaching Boys into Men and Founding Fathers.

"Several cities already have programs in place targeting men and boys, and this year alone, four national conferences are planned on the issue," Arean said.

"All of a sudden, it's like everyone is talking about it," he said. "It might not be a new idea, but it's an idea whose time might be coming in big-time right now."

Three years ago, activist Jackson Katz wrote "The Macho Paradox: Why Some Men Hurt and How All Men Can Help." His book called for a "far-reaching cultural revolution" among men that rejects some interpretations of masculinity.

One national organization, A Call to Men, was created nearly five years ago to change a "boys will be boys" attitude. Through community workshops, educators teach men to challenge definitions of manhood that they believe can perpetuate violence.

"We are part of the problem, though not intentionally," said co-founder Anthony Porter. "In this respect, silence is reaffirming."

Work done by groups like Guys Group and A Call to Men is gaining steam, advocates say, as they change their view of men from perpetrators to partners.

"It's been a bit of a shift in the wind the past few years," said Katherine Wessling of Legal Advocates for Abused Women. The group helps victims navigate the court system.

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"The best way men help this movement is by modeling for and telling other men that abusive behavior is not funny, is not normal, and is not OK," she said. (Munz, 2009)

—Reprinted from the February 17, 2009, issue of the *St. Louis Post-Dispatch* (MO).

Caregivers Should Get a Little TLC, Too: They Can Feel Overwhelmed and Alone, but Help Is out There

November is National Caregivers Month, established to honor those people who give up part or all of their lives to look after an incapacitated loved one. That care can last for a few weeks or until the relative dies.

Caregivers tend to have one thing in common, experts say. They accept the sacrifice and hardship and, most of all, the self-denial that goes with it.

But that may be a mistake, experts say. And if this month carries one message, it's this:

"Take care of yourself," said Rhonda Dahlbert, clinical manager for SSM Hospice. "Don't ever lose focus of what you need to do for yourself to stay healthy. Reach out. Don't be afraid to ask for help."

"There are a lot of support groups for caregivers. Every disease has a support group."

What is a caregiver?

The National Family Caregivers Association defines a caregiver as someone who sacrifices time and emotion for a disabled family member: "Simply put, family caregiving is the act of assisting someone you care about who is chronically ill or disabled and unable to care for himself or herself."

If only it were that simple.

Still, Jablonski says she feels particularly blessed. Her sister shares the responsibilities; her job has taught her how to be prepared for what has and will come.

The first preparation is love.

People who provide care for loved ones at home will say it's not about statistics. It's about one person dedicating his or her life to another—feeding, bathing, changing clothes, even changing diapers and doing similar tasks.

They say that while caregivers dedicate their lives to taking care of others, they must not forget to take care of themselves. "What help am I if I'm [incapacitated]?" Jablonski said.

A report issued by the Centers for Disease Control and Prevention, "The State of Aging and Health in America 2004," says:

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- Of those who provide 21 hours of care a week for a family member or friend, 61 percent have suffered depression.
- Older caregivers who have a history of chronic illness themselves and caregiving-related stress have a 63 percent higher death rate than their peers who are not caregivers.

There's even a name for the deterioration of a caregiver: "second patient syndrome," said Jason S. Carroll, assistant professor in the School of Family Life at Brigham.

"The stress and burden of caring for a spouse or parent can be consistent and demanding," he said. "Research indicates that family caregivers report poorer health, greater substance abuse, poorer emotional health, reduced social functioning and poorer financial status in comparison to other people their age."

So being a caregiver can be dangerous if you don't take care. The people performing the caregiving tasks may develop a need for care as much as the sick person.

A study by researchers at the University of Nevada said caregivers face several health [issues].

In addition, "Family caregivers who experience stressors that exceed their ability to cope are at increased risk for committing elder abuse," the study says. (Jackson, 2005)

—Reprinted from the November 7, 2005, issue of the *St. Louis Post-Dispatch* (MO).

As the stories at the start of this chapter illustrate, there are ingenious ways to organize communities around the issue of family violence. In the early days of social work, prevention was associated with the elimination of social ills contributing to social and personal dysfunctions. On a more global scale, the field of **prevention** science represents a concerted and coordinated effort to develop interventions that prevent the development of psychological, social, and/or physical outcomes. A disorder is identified, data are gathered, research is conducted, and services established. "The women's movement, Social Security, Medicare, the Civil Rights Laws and the Right to Education for All Handicapped Act have most benefited from Prevention Science initiatives" (Lurie & Monahan, 2001, p. 71).

Some experts identify three levels of prevention: primary, secondary; and tertiary (Lurie & Monahan, 2001; Thompson & Priest, 2005). **Primary prevention** is directed at the general population. It seeks to be proactive, by strengthening an individual's ability to cope with issues, and provides services such as public awareness campaigns, educational programs, and family support. **Secondary prevention** targets individuals and families who are either at risk or in the initial stages of experiencing problems, by providing services such as substance abuse treatment, home visitations, health care screenings, and respite care. **Tertiary prevention** targets individuals and families who are experiencing more intense levels of the problem and provides services such as intensive family preservation, mental health counseling, shelters, prosecution of

perpetrators, and rehabilitative programs; the aim of these services are to preclude further damage and reoccurrence of these symptoms.

Other, more recent frameworks exist for classifying prevention efforts and are fairly similar. "*Universal* strategies address the entire population without regard to risk; *selective* strategies target populations considered at heightened risk for violence; and *indicated* prevention efforts aim to intervene with those who have already demonstrated violent behavior" (Self-Brown & Whitaker, 2008, p. 400).

With these broader perspectives of prevention, an important factor that has particular resonance in the field of family violence is *resilience*. Resilience is associated with a person's ability to cope with major life stressor(s) and to succeed in the face of these adversities. Lurie and Monahan (2001) propose certain principles to include in preventive services that will increase clients' resilience. These principles can be integrated into practitioners' services, existing programs, and proposals for future programs:

1. Provide opportunities for education and employment to enhance clients' dignity.
2. Offer opportunities for clients to mentor others, thus, increasing self-esteem and awareness.
3. Offer referral services for clients who are at risk or actually experiencing health issues that manifest further stressful conditions.
4. Help clients develop interpersonal problem-solving skills.
5. Assist client in becoming involved with group activities to enhance interactions and attitudes.
6. Enhance clients' cultural sensitivity.
7. Identify incidents that can trigger recurrence of dysfunction.
8. Increase family and community support.

Preventing Child Maltreatment

The annual costs of child abuse and neglect in the United States is estimated at $258 million each day or $95 billion each year (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003). Direct costs include hospitalization, chronic health problems, and judicial system expenses, totaling $25 billion each year. Indirect costs include special education, mental health care, juvenile delinquency, lost productivity, and adult criminality, totaling $70 billion each year.

In efforts to prevent child maltreatment, the federal government funds numerous grant programs and supports the Child Abuse Prevention and Treatment Act (n.d.; Public Law 93-247). It was passed in 1974 and has undergone extensive revisions since that time to support child maltreatment prevention, assessment, investigation, prosecution, and treatment activities. Among these efforts was the formation of the national advocacy organization called Prevent Child Abuse America.

Prevention programs for children tend to fit into one of six categories: (a) public awareness; (b) skills-based curricula for children; (c) parent education programs and groups; (d) home visitation; (e) respite and crisis care; and

(f) family resources centers (Thomas et al., 2003). Brief examples of each are provided in the following pages.

Public Awareness

Public awareness campaigns can increase the public's understanding about family violence and means to prevent it. For example, awareness programs include programs such as Don't Shake the Baby, which targets shaken baby syndrome, STOP IT NOW!, which targets sexual abuse, and Stop Using Words That Hurt, against parents' psychological attacks on their children (Straus, 2000).

In many cases, awareness needs to be accompanied by additional policies that enable authorities to take actions that can prevent violence. For example, more awareness and policy work is needed on the relationship between violence and animal abuse (Randour, 2007). "Policy makers and practitioners are recognizing that the crime and behavior of animal cruelty, and its many implications for child development, juvenile delinquency, and family violence, and other crime, is a significant problem that needs to be addressed" (Randour, 2007, p. 101). Researchers, practitioners, and policy makers need a way to track animal cruelty and an increased recognition of animal cruelty as a sign of other forms of abuse. Treatment programs for animal abuse can help decrease these acts.

Another example in which research, policy, and public awareness programs are needed is in the link between corporal punishment (e.g., spanking) and family violence. "Corporal punishment is defined as the use of physical force with the intention of causing a child to experience pain, but not injury, for the purpose of correction or control of the child's behavior" (Straus, 2000, p. 1110). Some studies have found that spanking can lead to delinquent and antisocial behavior in childhood along with spousal or child abuse later on (e.g., Gershoff, 2002). This research suggests that antispanking campaigns and programs may help decrease the usage of spanking and thus prevent escalation to more severe forms of abuse.

Curricula for Children

Skills-based curricula for children can include child-friendly and engaging materials and media such as workshops, puppet shows, films, and workbooks. For example, there are the Coordinated School Health Programs (CSHPs), which serve maltreated children and are designed to deal with their medical, emotional, psychological, and behavioral problems. CSHPs include four components: health education, health services, counseling, and community involvement (Massey-Stokey & Lanning, 2004).

Another example is the Chicago Child-Parent Center (CPC) program (Mann & Reynolds, 2006). The CPC provides services to children at risk of juvenile delinquency, including intervention prior to primary school, structured learning approaches, collaboration between families and school, and continuity of care. The Chicago Longitudinal Study investigated the long-term outcomes of the CPC and found that over a 15-year period, this large-scale preschool program reduced the incidence, frequency, and severity of juvenile crime.

Parent Education Programs

Parent education programs and groups provide information, support, mentoring, and self-help for future, expecting, and present parents. For example, Options Daycare is a part of the Victoria Society for Educational Alternatives and is a child care program that models effective parenting behaviors for at-risk mothers who have young children with aggressive tendencies. The program teaches the children how to self-regulate their aggression, thus increasing their interpersonal skills as they mature (Nicholson & Artz, 2006). Whereas most child care programs have multiple adults caring for all the children, this program assigns one caregiver to each child. The caregiver interacts with the child and models language for free play, for times when the child becomes aggressive, and for times when the child is upset. The mothers observe the interaction and are taught to continue constructive interactions with their child at home.

Home Visitation Programs

Home visitation programs have proven effective with high-risk populations of low-income families and first-time mothers to improve pregnancy outcomes, promote health, and strengthen families (Sacco, Twemlow, & Fonagy, 2007). Surveys have found that Multiple Problem Families (MPFs) use a disproportionately high percentage of social services, including those serving substance abuse, mental health, and Children's Protective Services (CPS). Providing these families in-home, intensive, community-based treatment is cost-effective compared with inpatient and residential care. Preventive services reduce the family's stress and helps deal with issues before they become crises.

Respite and Crisis Care Programs

Respite and crisis care programs and Family Resources Center programs provide parents with an opportunity to have time away from potentially volatile situations and to receive referrals and case management services. Services include hotlines, crisis caretakers, crisis babysitters, crisis nurseries, and crisis counseling. These services help alleviate various stressors in parents' lives.

Public Health Campaigns

Various public health campaigns use mass communication and information technology to prevent child maltreatment (CM; Self-Brown & Whitaker, 2008). Technology can identify risk factors for CM, delivery of CM programs, and dissemination of evidence-based programs. Screenings can be conducted in numerous large settings such as in health departments and in schools to determine risk factors in the home and in schools. Screenings are valid, inexpensive, replicable, and time-saving.

Clinical assessments can be conducted using standardized instruments, which are rapidly administered and processed. The Multidimensional Neglectful Behavior Scale-Child Report (MNBS-CR; Kaufman Kantor et al., 2004) measures risk for child maltreatment and is administered to children using a computer-based version (Self-Brown & Whitaker, 2008). This type of adminis-

tration takes less time to complete than the face-to-face versions and instantly generates scores (McLellan et al., 1992).

Telephones can be used in the assessment process as a quick means to identify health problems and obtain baseline measures of youth and their parents (Self-Brown & Whitaker, 2008). Using interactive voice response (IVR), prerecorded voice prompts and menus present information with options that clients respond to by using telephone keypads. Webcams and wireless receivers enable therapists to record problem behaviors. Lanzi and colleagues (2007) used cell phone methodology for assessing its use with high-risk mothers and concluded 32% of participants indicated that calls provided reminders as to proper parenting.

Television has long been used to promote public awareness. The Internet can deliver public health information to a broad audience, and provides means for parents to communicate with one another. Virtual reality application integrates "computer graphics, sounds and other sensory input to create a computer-generated world with which the user can interact" (Self-Brown & Whitaker, 2008, p. 406). DVDs, videos, and CD-ROMs are delivered with computers, televisions, and other products. Through technology—including computers, internet, telephones, video cameras, telemetrics, television, radio, video, and video games—social workers and other professionals can enhance the provision of services to clients through screenings, assessments, and interventions.

"The National Center on Shaken Baby Syndrome (NCSBS) and Ronald Barr have developed the *Period of PURPLE Crying* intervention materials, which consist of a DVD and booklet, and address parental response to crying, a period of high risk for caregiver shaking to occur" (Self-Brown & Whitaker, 2008, p. 406). A DVD course for foster parents was effective in improving their knowledge and self-perceptions in relation to child behavior (Pacifici, Delaney, White, Cummings, & Nelson, 2005). Parenting Wisely (PW) is a program that has been found successful in teaching parenting skills to high-risk families using a CD-ROM (Gordon, 2000).

Technological advances do present their own difficulties, such as the lack of empathy that can be communicated to clients, difficulties in billing insurance companies, and the "digital divide" that results in lack of access by low-income persons. Ethical dilemmas include assuring security to private information and the safety of children who may be endangered.

Program Evaluation

Program evaluation is required to measure the effectiveness and efficiency with which prevention programs achieve their goals, thus providing an evidence base with which to justify their continued usage, need for revision, or discontinuance. Proactive programs (e.g., home visiting, general education, networking, and media presentations) tend to work with families having infants and young children; whereas reactive programs (intensive family preservation, multicomponent programs, and parent training) work with families having older children and teenagers (MacLeon & Nelson, 2000).

The results of various studies disagree as to the effectiveness of sexual abuse prevention programs. Some studies report favorable results, such as a decrease in the amount of reported sexual abuse (Gibson & Leitenberg, 2000),

an increase in children's knowledge, and an increase in their self-protection strategies (Finkelhor & Dziuba-Leatherman, 1995). Other studies report that exposure to these programs increases children's fear; although such programs may increase children's knowledge about protection, they fail to help children protect themselves from abuse (Bolen, 2003; Dake, Price, & Murman, 2003).

Effective programs are based on an ecological model that targets all systems levels with the intent of changing the smaller targeted system (individuals and families) to adapt to their environment and altering the environment (organizations and communities) to be more accommodating to their subsystems (e.g., individuals and families). Effective programs adopt comprehensive strategies, reflect the phases of the family life cycle, and prevent abuse before it occurs (Massey-Stokey & Lanning, 2004). Overall, the best strategies for preventing child maltreatment are intensive versus brief or superficial; comprehensive versus focused on a piece of the problem; and flexible versus assuming that the same approach works for everyone. Successful strategies include comprehensive, collaborative services for all families (e.g., supportive program for new parents and access to parenting information); an array of specialized and intensive services for families at risk (e.g., home visiting, low-cost counseling, substance abuse counseling, domestic violence intervention, and respite care); primary prevention (public awareness); and communitywide focus (schools, businesses, faith communities, health care providers, and civic organizations).

Preventing Intimate Partner Violence

The cost of intimate partner violence is estimated to exceed $8.3 billion annually, including medical and mental health care, lost productivity, and the amount of income persons could earn if they were not incapacitated by injury and/or prevented from working by a partner (Tjaden & Thoennes, 2000). The most effective solutions to preventing partner violence typically utilize a community effort. The Coordinated Community Action Model (Garvin & Jackson, 2003) is commonly used in providing guidelines for professional groups desiring to prevent or ameliorate partner violence in their community (see Figure 17.1). The spokes in the wheel represent strategies for protecting potential, present, and past victims and for holding perpetrators accountable for their behaviors. Strategies are provided for professionals within social services, health care, justice system, education, clergy, media, and government along with all employers and every member of the community.

Another useful prevention tool is the *Toolkit to End Violence Against Women* (n.d.), which was written by the National Advisory Council on Violence Against Women. Each of the publication's 16 chapters provides recommendations and resources (including lists of websites) targeting a different audience or environment, as follows: (a) community-based services, (b) health and mental health care, (c) civil justice, (d) criminal justice, (e) other justice system personnel, (f) economic security, (g) higher education campuses, (h) workplaces, (i) children and youth, (j) educating the public, (k) media and entertainment, (l) faith-based groups, (m) sports, (n) Native women, (o) U.S. military, and (p) international communities. The *Toolkit* is available at http://toolkit.ncjrs.org/.

17.1

Coordinated community action model.

Social workers in health care settings are in a unique position to help screen and assess women for the presence of domestic violence (Murphy & Ouimet, 2008). The Centers for Disease Control (CDC) and the National Association of Social Workers (NASW) have recommended routine screenings in health care centers where women can be made to feel comfortable discussing their home situations, including the possibility of abuse. The CDC also has a listing of prevention programs and resources, available at http://www.cdc.gov/Violence Prevention/intimatepartnerviolence/prevention.html.

Women can increase their risk of intimate partner violence by being sensitive to their own instincts if they feel they are being threatened physically, psychologically, and/or cognitively. This theory of "mindful spaces" expands the definition of partner violence to include less overt acts, thus, acting in its early stages of onset (Burlae, 2004). For example, women should be cognizant of signs such as decreased sleep, increased anxiety, worsening depression, and/or other negative physiological cues, which may be physiological warning signs.

Intimate partner violence is an internationally recognized problem. In 1993, the World Conference on Human Rights in Vienna developed the Declaration on Elimination of Violence Against Women to align women's rights with human rights and to charge universal protection of women from violence (Morgaine, 2006). In 1995, at the World Conference on Women, violence against women (VAW) was the hallmark of international efforts to gain international acceptance of women's rights as human rights.

The ability to prevent violence against women on a global basis requires cultural competence of all parties (Ritchie & Eby, 2007). This remains a daunting undertaking considering the multicultural aspects including varying needs, interpretations, religions, politics, legalities, and societies. The definitions of "violence" and conceptualizations of "justice" are embedded in political and theological cultural interpretations (Morgaine, 2006).

Social workers are at the forefront of framing and solving social issues (Morgaine, 2006; Ritchie & Eby, 2007). An increased involvement with social workers across the world, in recognition of globalization, is imperative and can be achieved with increasing multicultural knowledge.

Preventing Elder Abuse

The financial cost of elder abuse victimization is presently unknown (Stiegel, 2004); this reflects the lack of research into the issue (particularly as compared to child abuse and intimate partner violence). One important first step to make elder abuse as recognized as other types of family violence is to agree upon the definition of what constitutes elder abuse, as well as systematic nationwide measures of reporting and responding to such abuse.

Multidisciplinary teams (MDTs) can be formed throughout communities to provide prevention awareness and programs in the form of coordinated services to older adults (Nerenberg, 2006; Reingold, 2006). Members of these teams include health and social service providers, physicians, advocates, law enforcement, Ombudsmen, advocates for persons with disabilities, attorneys, domestic violence advocates, case managers, financial institutions, and money managers. Financial abuse specialist teams (FAST) are a type of MDT that include ad-

ditional representatives from real estate, insurance, banking, trusts, and estate planning. Within these forums members can learn what services, approaches, and resources are available and can share information and expertise as well as identify and respond to problems.

A coordinated response for preventing elder abuse is needed on the federal level to coordinate abuse reporting and to establish guidelines for service delivery. Presently, each state implements its own reporting systems and programs. States vary as to their definition of elder abuse, eligibility for services, and responses to reports. A federally-funded agency for addressing these problems could provide the continuous collection of accurate, uniform data at both the state and national levels (Nerenberg, 2006). Toward this end, the Elder Abuse Justice Act of 2007, a proposed amendment to the Social Security Act, has been pending in Congress for a number of years and is intended to establish a coordinated federal response for the prevention of elder abuse. The federal office would be housed the U.S. Department of Health and Human Services and the Department of Justice. Various services would be provided including data collection, public awareness campaigns, and a national library.

Part of providing prevention services for the elderly entails providing assistance to their families and friends, especially those who are caregivers. According to Administration on Aging (U.S. Department of Health and Human Services, n.d.), more than 23 million Americans serve as family or informal caregivers. Most (85%) of the caregivers have no outside paid help, and 72% are women. The more support caregivers have, the better quality of life they can provide for their elders.

Meeting caregivers' needs was the motivating force behind the National Family Caregiver Support Program (Nerenberg, 2002), which was enacted under the Older American Act Amendment of 2000. This program was developed by the Administration on Aging of the U.S. Department of Health and Human Services and calls for state governmental agencies to collaborate with Area Agencies on Aging, faith-based providers, and other community representatives to provide five direct services for caregivers of the elderly: (a) information about available services; (b) assistance in gaining access to supportive services; (c) individual counseling, support groups and training; (d) respite care; and (e) supplemental services. This program is one way the federal government can help meet the needs of caregivers to the elderly.

Summary

The national costs of family violence are estimated at over $100 billion for direct and indirect costs including physical and mental health, law enforcement, courts, and a host of other services. In a given year, the federal government spends an estimated $15 billion in funding family violence programs (Goldman & Wolcott, 2003; U.S. Department of Health and Human Services, n.d., 2003).

Much remains to be done to eradicate family violence. For people to be protected, they need to be valued, which would include changing societal attitudes toward children, women, and elders. A federal governmental response is needed to pass legislation, establish policies, and provide funding. Programs require continued evaluation to determine their effectiveness. Violence within

our homes is everyone's problem, everyone's business, and everyone's responsibility.

Stories about projects and programs aimed at preventing family violence provide ideas for other communities to adopt in their efforts toward discontinuing violence among family members. The story below represents other prevention programs; see also Appendix C for websites of various major prevention programs throughout the nation. Persons who successfully implement these programs are urged to publish their successes so other communities can benefit.

Project HART Teaches Teens How to Avoid or Escape Abuse

On a Monday morning in mid-October, Angie Light is trying to draw out the 12 students in Mrs. Smith's eighth-grade class on the subject of abusive relationships. Stevens Middle School is in a St. Louis neighborhood that once was prosperous with middle-class brick rowhouses. Now more than half the lots are empty, like missing teeth. The school itself is neat and modern, but the windows are heavily screened, and there are no handles on the outside doors; you have to ring a bell to gain admission.

Qiana Lewis, the school's coordinator of community outreach, the woman who brought Angie Light here to speak, says, "The children at our school just haven't been exposed to very much that's positive."

Often their parents aren't around or are on drugs. "Some have never seen their dads," she says. "Considering the students we deal with, I know a lot of them are in homes where they're being abused."

So it made sense to set aside an hour a day this week, in every eighth-grade class, to talk about abuse, a topic that can make administrators in many schools a bit nervous.

Light, an intense young woman who runs the Women's Support and Community Services Center's Project Healthy Alternatives for Relationships Among Teens, has picked one of the most likable students to illustrate a point. She warns him she's only role-playing, then swipes her hand in his general direction.

"If I went up to you each morning and said, 'Perry, you're so stupid; Perry, you're so ugly,' if I did that because I didn't want him to come to school anymore, would that be violence or abuse?" she asks. "That would be abuse because it's a pattern, and I'm trying to control him. Got it?"

Whether they get it or not, the students are suddenly attentive, whereas a moment ago they were listless, bored and holding side conversations. They go back and forth like that the whole hour, often straying from a point just after they've been laboriously brought to it.

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Project HART has been taking its anti-abuse program into schools and juvenile-detention facilities since 1988, both in the city and throughout St. Louis County. . . .

The results aren't always the same. "When we go to CBC, it's completely different," Light says, because it's an all-boys school, where she has to be especially careful not to sound like she's bashing men.

The schools also differ on how receptive they are to letting Project HART in at all. "Most of the schools are very open, and they welcome the anger-management parts, family violence even—but when you're talking about sexual harassment, they're not so sure," Light says. "At the middle-school level, some of the teachers and administration don't feel that their students need that information. They think, 'Our students at this level aren't dating.' So we want to make sure they understand this is a prevention program."

Light shows them information that youths should learn about date rape before they're exposed to the possibility, but if the teachers still are reluctant, she'll demur.

On Friday, Light is wrapping up the week with a session on acquaintance rape. Just as on Monday, the students in Mrs. Smith's class are listless and interested by turns. The director of the women's center, Barbara Bennett, says, "I think we all have to admit that what we're doing here is planting the seeds."

It's the end of the school day. The students bolt out the door the moment class ends, head into the weekend and leave Mrs. Smith and Light to tidy up and turn out the lights. As they're approaching the door, Mrs. Smith turns to ask, "So when do you think you're going to be coming back?"

Project HART . . . was created 13 years ago by the nonprofit group Women's Support and Community Services to educate middle-school and high-school-age boys and girls about abusive relationships and how to avoid or get out of them. (Art Charity of the *Post-Dispatch,* 2001)

—Reprinted from the October 29, 2001, issue of the *St. Louis Post-Dispatch* (MO).

Discussion Questions

1. The above articles mention many types of prevention programs and strategies. Which of these strategies do you believe would be helpful in your community?
2. Given the many ideas presented for preventing family violence, design your own program. What would it look like? Who would it serve? How would you determine your program's effectiveness?

Key Terms

Prevention
Primary prevention
Program evaluation
Secondary prevention
Tertiary prevention

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Appendix A

Child Protective Services by State

State toll-free numbers for specific agencies designated to receive and investigate reports of suspected child abuse and neglect (Child Welfare Information Gateway, n.d.) (http://www.childwelfare.gov/index.cfm).

Alabama

Local (toll): (334) 242-9500
http://www.dhr.state.al.us/page.asp?pageid=304

Alaska

Toll-Free: (800) 478-4444
http://www.hss.state.ak.us/ocs/default.htm

Arizona

Toll-Free: (888) SOS-CHILD (888-767-2445)
https://www.azdes.gov/dcyf/cps/reporting.asp

Arkansas

Toll-Free: (800) 482-5964
http://www.state.ar.us/dhs/chilnfam/child_protective_services.htm

California

http://www.dss.cahwnet.gov/cdssweb/PG20.htm
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Colorado

Local (toll): (303) 866-5932
http://www.cdhs.state.co.us/childwelfare/FAQ.htm

Connecticut

Toll-Free: (800) 842-2288
TDD: (800) 634-5518
http://www.state.ct.us/dcf/HOTLINE.htm

Delaware

Toll-Free: (800) 292-9582
http://www.state.de.us/kids/

District of Columbia

Local (toll): (202) 671-SAFE (202-671-7233)
http://cfsa.dc.gov/cfsa/cwp/view.asp?a=3&q=520663&cfsaNav=|31319|

Florida

Toll-Free: (800) 96-ABUSE (800-962-2873)
http://www.dcf.state.fl.us/abuse/

Georgia

http://dfcs.dhr.georgia.gov/portal/site
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Hawaii

Local (toll): (808) 832-5300
http://www.hawaii.gov/dhs/protection/social_services/child_welfare/

Idaho

Toll-Free: (800) 926-2588
http://www.healthandwelfare.idaho.gov/site/3333/default.aspx

Illinois

Toll-Free: (800) 252-2873
Local (toll): 217 524-2606
http://www.state.il.us/dcfs/child/index.shtml

Indiana

Toll-Free: (800) 800-5556
http://www.in.gov/dcs/protection/dfcchi.html

Iowa

Toll-Free: (800) 362-2178
http://www.dhs.state.ia.us/dhs2005/dhs_homepage/children_family/abuse_reporting/child_abuse.html

Kansas

Toll-Free: (800) 922-5330
http://www.srskansas.org/services/child_protective_services.htm

Kentucky

Toll-Free: (800) 752-6200
http://chfs.ky.gov/dcbs/dpp/childsafety.htm

Louisiana

http://www.dss.state.la.us/departments/ocs/Reporting_Child_Abuse-Neglect.html
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Maine

Toll-Free: (800) 452-1999
TTY: (800) 963-9490
http://www.maine.gov/dhhs/bcfs/abusereporting.htm

Maryland

http://www.dhr.state.md.us/cps/report.htm
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Massachusetts

Toll-Free: (800) 792-5200
http://mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Consumer&L2=Family+Services&L3=Violence%2c+Abuse+or+Neglect&L4=Child+Abuse+and+Neglect&sid=Eeohhs2&b=terminalcontent&f=dss_c_can_reporting&csid=Eeohhs2

Michigan

http://www.michigan.gov/dhs/0,1607,7-124-5452_7119_7193-15252—,00.html
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Minnesota

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000152
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Mississippi

Toll-Free: (800) 222-8000
Local (toll): (601) 359-4991
http://www.mdhs.state.ms.us/fcs_prot.html

Missouri

Toll-Free: (800) 392-3738
Local (toll): (573) 751-3448
http://www.dss.mo.gov/cd/rptcan.htm

Montana

Toll-Free: (866) 820-5437
http://www.dphhs.mt.gov/cfsd/index.shtml

Nebraska

Toll-Free: (800) 652-1999
http://www.hhs.state.ne.us/cha/chaindex.htm

Nevada

Toll-Free: (800) 992-5757
http://dcfs.state.nv.us/DCFS_ReportSuspectedChildAbuse.htm

New Hampshire

Toll-Free: (800) 894-5533
Local (toll): (603) 271-6556
http://www.dhhs.state.nh.us/DHHS/BCP/default.htm

New Jersey

Toll-Free: (877) 652-2873
TDD: (800) 835-5510
TTY: (800) 835-5510
http://www.state.nj.us/dcf/abuse/how/

New Mexico

Toll-Free: (800) 797-3260
Local (toll): (505) 841-6100
http://www.cyfd.org/report.htm

New York

Toll-Free: (800) 342-3720
Local (toll): (518) 474-8740
TDD: (800) 369-2437
http://www.ocfs.state.ny.us/main/cps/

North Carolina

http://www.dhhs.state.nc.us/dss/cps/index.htm
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

North Dakota

http://www.nd.gov/dhs/services/childfamily/cps/#reporting
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Ohio

http://jfs.ohio.gov/county/cntydir.stm
Contact the county Public Children Services Agency using the list above or call Childhelp (800-422-4453) for assistance.

Oklahoma

Toll-Free: (800) 522-3511
http://www.okdhs.org/programsandservices/cps/default.htm

Oregon

http://www.oregon.gov/DHS/children/abuse/cps/report.shtml
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Pennsylvania

Toll-Free: (800) 932-0313
http://www.dpw.state.pa.us/ServicesPrograms/ChildWelfare/003671030.htm

Puerto Rico

Toll-Free: (800) 981-8333
Local (toll): (787) 749-1333
Spanish Information on Website: http://www.gobierno.pr/GPRPortal/StandAlone/AgencyInformation.aspx?Filter=177

Rhode Island

Toll-Free: (800) RI-CHILD (800-742-4453)
http://www.dcyf.ri.gov/child_welfare/index.php

South Carolina

Local (toll): (803) 898-7318
http://www.state.sc.us/dss/cps/index.html

South Dakota

http://dss.sd.gov/cps/protective/reporting.asp
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Tennessee

Toll-Free: (877) 237-0004
http://state.tn.us/youth/childsafety.htm

Texas

Toll-Free: (800) 252-5400
https://www.dfps.state.tx.us/Child_Protection/About_Child_Protective_Services/reportChildAbuse.asp

Utah

Toll-Free: (800) 678-9399
http://www.hsdcfs.utah.gov

Vermont

24 hours: (800) 649-5285
http://www.dcf.state.vt.us/fsd/reporting_child_abuse

Virginia

Toll-Free: (800) 552-7096
Local (toll): (804) 786-8536
http://www.dss.virginia.gov/family/cps/index.html

Washington

Toll-Free: (866) END-HARM (866-363-4276)
After hours: (800) 562-5624
TTY: (800) 624-6186
http://www1.dshs.wa.gov/ca/safety/abuseReport.asp?2

West Virginia

Toll-Free: (800) 352-6513
http://www.wvdhhr.org/bcf/children_adult/cps/report.asp

Wisconsin

http://dcf.wisconsin.gov/children/CPS/cpswimap.HTM
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Wyoming

http://dfsweb.state.wy.us/menu.htm
Click on the website above for information on reporting or call Childhelp (800-422-4453) for assistance.

Appendix B

Adult Protective Services Hotline Numbers by State

Below is a list of the hotline numbers and websites for reporting elder abuse in the community and in long term care facilities, as listed by each state and the District of Columbia. This information is provided by the National Center on Elder Abuse (http://www.ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/Help_Hotline.aspx). Missing telephone numbers or website addresses indicate that they were the same for the community and for the long-term-care facilities.

Report Elder Abuse Domestic/ Community	**Report Abuse in Nursing Home Long Term Care Facility**
Alabama	
800-458-7214 http://www.dhr.state.al.us/page.asp?pageid=274	800-458-7214
Alaska	
800-478-9996 http://www.hss.state.ak.us/dsds/aps.htm	800-730-6393
Arizona	
877-767-2385 https://egov.azdes.gov/cmsinternet/common.aspx?	Same
Arkansas	
800-332-4443 http://www.aradultprotection.com	800-582-4887 http://www.arombudsman.com/
California	
888-436-3600 http://www.dss.cahwnet.gov/cdssweb/PG79.htm	800-231-4024 http://www.agijng.ca.gov.html/programs/ombudsman.html

Report Elder Abuse Domestic/ Community	Report Abuse in Nursing Home Long Term Care Facility
Colorado	
800-773-1366 http://www.cdhs.state.co.us/aas/adultprotection_index.htm	800-773-1366 http://www.cdphe.state.co.us/hf/static/ncfcomp.htm
Connecticut	
888-385-4225 http://www.ct.gov/dss/site/default.asp	860-424-5241
Delaware	
800-223-9074 http://www.dhss.delaware.gov/dhss/dsaapd/aps.html	800-223-9074
District of Columbia	
202-541-3950 http://www.dhs.dc.gov/dhs/cwp/view,a,3,q,492691,dhsNav,30980.asp	202-434-2140
Florida	
800-962-2873 http://www.dcf.state.fl.us/as/	Same
Georgia	
888-774-0152 http://aging.dhr.georgia.gov/	800-878-6442
Hawaii	
808-832-5115 (Oahu) 808-243-5151 (Maui, Molokai, and Lanai) 808-241-3432 (Kauai) 808-933-8820 (East Hawaii) 808-327-6280 (West Hawaii) http://www4.hawaii.gov/	808-832-5115(Oahu) 808-243-5151 (Maui, Molokai, and Lanai) 808-241-3432 (Kauai) 808-933-8820 (East Hawaii) 808-327-6280 (West Hawaii)
Idaho	
800-471-2777 http://www.idahoaging.com/programs/ps_adultprotect.htm	877-471-2777
Illinois	
866-800-1409 http://www.state.il.us/aging/1abuselegal/abuse.htm	800-252-4343 http://www.state.il.us/aging/1abuselegal/ombuds_reporting.htm

Report Elder Abuse Domestic/ Community	Report Abuse in Nursing Home Long Term Care Facility
Indiana	
800-992-6978 http://www.in.gov/ai/errors/fssa_404.html	800-992-6978
Iowa	
800-362-2178 http://www.dhs.iowa.gov/advocacy/ombudsman.html#ltccomp	877-686-0027 http://www.state.ia.us/elderaffairs/
Kansas	
800-922-5330 http://www.srskansas.org/ISD/ees/adult.htm	800-842-0078 http://ag.ky.gov/civil/medicaidfraud/
Kentucky	
800-752-6200 http://chfs.ky.gov/dcbs/dpp/eaa/	Same http://ag.ky.gov/civil/medicaidfraud/
Louisiana	
800-259-4990 http://ltp-76b.portal.louisiana.gov/elderlyaffairs/eps.htm	Same
Maine	
800-624-8404 http://www.maine.gov/dhhs/oes/aps.htm	800-383-2441 http://www.maine.gov/dhhs/oes/resource/anequide.htm
Maryland	
800-917-7383 http://www.dhr.state.md.us/how/srvadult/protect.htm	Same
Massachusetts	
800-922-2275 http://www.sec.state.ma.us/cis/ciscig/o/o6o15.htm	800-462-5540
Michigan	
800-996-6228 http://www.michigan.gov/dhs/html	800-882-6006

Report Elder Abuse Domestic/ Community	Report Abuse in Nursing Home Long Term Care Facility
Minnesota	
800-333-2433 http://www.dhs.state.mn.us/	800-333-2433
Mississippi	
800-222-8000 http://www.mdhs.state.ms.us/fcs_aps.html	800-227-7308
Missouri	
800-392-0210 http://www.dhss.mo.gov/ProtectiveServices/	Same
Montana	
800-551-3191 http://www.dphhs.mt.gov/index.shtml	800-551-3191
Nebraska	
800-652-1999 http://www.hhs.state.ne.us/ags/aps.htm	Same
Nevada	
800-992-5757 http://www.nvaging.net/protective_svc.htm	Same
New Hampshire	
800-351-1888 http://www.dhhs.state.nh.us/DHHS/BEAS/adult-protection.htm	800-442-5640
New Jersey	
800-792-8820 http://www.state.nj.us/health/senior/aps.shtml	Same
New Mexico	
866-654-3219 http://www.nmaging.state.nm.us/	800-432-2080

Report Elder Abuse Domestic/ Community	Report Abuse in Nursing Home Long Term Care Facility
New York	
800-342-3009 http://www.ocfs.state.ny.us/main/psa/	888-201-4563 http://www.health.state.ny.us/facilities/nursing
North Carolina	
800-662-7030 http://www.dhhs.state.nc.us/aging/adultsvcs/afs_aps.htm	Same
North Dakota	
800-451-8693 http://www.nd.gov/dhs/services/adultsaging/vulnerable.html	Same
Ohio	
866-635-3748 http://aging.ohio.gov/families/aps.html	800-342-0533 http://www.odh.ohio.gov/odhPrograms/
Oklahoma	
800-522-3511 http://www.okdhs.org/APS/contactus.html	Same
Oregon	
800-232-3020 http://www.oregon.gov/	800-522-2602
Pennsylvania	
800-490-8505 http://www.aging.state.pa.us/aging/	800-254-5164 http://www.dsf.health.state.pa.
Rhode Island	
401-462-0550 http://www.dea.ri.gov/programs/protective_services.php	401-785-3340
South Carolina	
803-898-7318 http://dss.sc.gov/content/customers/protection/index.aspx	800-868-9095 http://www.aging.sc.gov/Seniors/Ombudsman.htm

Report Elder Abuse Domestic/ Community	Report Abuse in Nursing Home Long Term Care Facility
South Dakota	
605-773-3656 http://dss.sd.gov/	Same
Tennessee	
888-277-8366 http://www.state.tn.us/	Same
Texas	
800-252-5400 http://www.dfps.state.tx.us /	800-458-9858
Utah	
800-371-7897 http://www.hsdaas.utah.gov/ ap_referral.htm	Same
Vermont	
800-564-1612 http://www.dad.state.vt.us/lp/aps.htm	Same
Virginia	
888-832-3858 http://www.dss.virginia.gov/ family/as/aps.cgi	Same
Washington	
866-363-4276 http://www.adsa.dshs.wa.gov/	800-562-6078
West Virginia	
800-352-6513 http://www.wvdhhr.org/bcf/ children_adult/aps/report.asp	Same
Wisconsin	
800-815-0015 http://dhs.wisconsin.gov/aging/ elderabuse/index.htm	608-266-2536
Wyoming	
800-457-3659 http://dfsweb.state.wy.us/aps.htm	Same http://www.wyomingseniors.com/ ombudsman.htm

Appendix C

Prevention Programs

Child Abuse and Neglect

Child Welfare Information Gateway

Children's Bureau/ACYF
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
800-394-3366 or 703-385-7565
http://www.childwelfare.gov/contact.cfm

Prevent Child Abuse America

500 North Michigan Avenue
Suite 200
Chicago, IL 60611-3703
312-663-3520
http://www.preventchildabuse.org/index.shtml

Child Abuse Prevention Association—CAPA

503 E. 23rd Street
Independence, MO 64055
816-252-8388
http://www.childabuseprevention.org/About/

Child Molestation Research & Prevention Institute

1401 Peachtree Street, Suite 120
Atlanta, GA 30309
404-872-5152
http://childmolestationprevention.org/pages/about.html

Intimate Partner Abuse

Office on Violence Against Women (OVW)

800 K Street, NW, Suite 920
Washington, DC 20530
202-307-6026
www.usdoj.gov/ovw

Centers for Disease Control and Prevention National Center for Injury Prevention and Control (NCIPC)

4770 Buford Hwy, NE
MS F-63
Atlanta, GA 30341-3717
800-CDC-INFO
(800-232-4636)
http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html

National Coalition Against Domestic Violence (NCADV)

1120 Lincoln Street, Suite 1603
Denver, CO 80203
303-839-1852
http://mainoffice@ncadv.org

Family Violence Prevention Fund

383 Rhode Island St., Suite 304
San Francisco, CA 94103-5133
415-252-8900
http://endabuse.org/

Center Against Domestic Violence

25 Chapel Street, Suite 904
Brooklyn, NY 11201
718-254-9134
http://www.centeragainstdv.org/

National Organization for Women (NOW)

P.O. Box 1848
Merrifield, VA 22116-8048
202-628-8669
http://www.now.org/

Elder Abuse

National Center on Elder Abuse

c/o Center for Community Research and Services
University of Delaware
297 Graham Hall
Newark, DE 19716
http://www.ncea.aoa.gov/ncearoot/Main_Site/index.aspx

"Not Forgotten" Campaign of the Texas Department of Protective and Regulatory Services (TDPRS)

Office of the District Attorney
Victim Services Division
County of Ventura
Hall of Justice
800 South Victoria Avenue
Ventura, CA 93009
805-654-3314
http://www.ncea.aoa.gov/NCEAroot/Main_Site/Resources/Community/Outreach/_Kit/Chapter4/Ch4_1_b.aspx

The Center for Advocacy for the Rights and Interests of the Elderly (CARIE)

100 S. Broad Street
1500 Land Title Building
Philadelphia, PA, 19110
215-545-5728
800-356-3606
http://www.carie.org/index.php

The National Committee for the Prevention of Elder Abuse (NCPEA)

1612 K Street, NW
Washington, DC 20006
202-682-4140
202-223-2099 (fax)
http://www.preventelderabuse.org/

The WISE & Healthy Aging Elder Abuse Prevention Program

1527 4th St., 2nd Floor
Santa Monica, CA 90401
310-394-9871
http://www.wiseandhealthyaging.org/cms/1028.html

American Association of Retired Persons (AARP)

601 E Street, NW
Washington, DC 20049
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