Issues in Children's and Families' Lives
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# INTERPERSONAL VIOLENCE IN THE AFRICAN-AMERICAN COMMUNITY

## Evidence-Based Prevention and Treatment Practices

Edited by
Robert L. Hampton
and
Thomas P. Gullotta

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# Preface

## *Interpersonal Violence and the African-American Family*

This latest Hartman Scholars volume is devoted to examining the state of knowledge as it applies to violence within the African-American family. As in previous volumes undertaken in the Hartman scholars program, we selected an interdisciplinary group of scholars and practitioners from across the United States. The Hartman scholars program has been in existence for more than a decade. During that time, we have selected social issues of pressing concern and explored in a learning community format how these issues might be best addressed. The issue of interpersonal violence is not unique to the African-American family. What is unique is their experience with slavery, with persistent racism, and in their overrepresentation in the child welfare system and in the criminal justice system. The individuals chosen for this learning community operated shelters and taught. They were individuals whose scholarly interest were children, couples, grandparents, the church, or African-rooted spirituality.

Not surprisingly, our meetings during the past year were lively and those discussions added enormously to the chapters that are before you. This volume speaks both to what is known and what is not known. As the reader will soon discover, contrary to popular belief, ethnic and racial research is the exception rather than the norm. Evidence-based practice derived from that research is virtually nonexistent. To develop effective interventions to treat and, better yet, prevent family violence requires a more comprehensive grasp of the cultural complexity of families than currently exists.

This volume is a starting point in the creation of that knowledge base, with Bob Hampton and William Oliver, in the first Chapter, providing an overview of violence in the black family, identifying gaps in that knowledge, and offering an agenda to closing the breaks in that knowledge base. The next two Chapters blend treatment with prevention to

examine child abuse and couple abuse. After detailing the circumstances of African-American children in the child welfare system, Harden and Nzinga-Johnson suggest several efforts worthy of evaluation. In Chapter 3, Kaslow and her associates build on this effort, examining in detail the current state of evidence-based research and separating child abuse program evaluations into what works, what might work, and what does not work. From this review, specific recommendations are offered.

The next Chapter by Brian Jory provides a transition from child to couple-focused and extended-family issues. Jory examines the most commonly used family violence assessment instruments for appropriateness, the shortcomings of family violence treatment, and the potential value of intimate justice. In Chapter 5, Bent-Goodley addresses the sensitive issue that violence rarely occurs in a vacuum. Her chapter examines the role of the African-American church in addressing or not addressing family violence. This is followed by Rodger's discussion of her use of African-American nonreligious spirituality to achieve nonviolence; and in Chapter 7, Bullock shares with the reader the experiences of grandparents raising their grandchildren. This volume concludes with Crusto and her associates examining the challenges of field research and offering suggestions on undertaking those efforts.

This volume serves as a base for practitioners, scholars, and students to develop evidence-based practices that originate within the African-American experience and encourage the healthy development of child, woman, and man.

Robert L. Hampton
Thomas P. Gullotta

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# Interpersonal Violence in the African-American Community

*Evidence-Based Prevention and Treatment Practices*

# Chapter 1

# Violence in the Black Family: What We Know, Where Do We Go?

Robert L. Hampton and William Oliver

## Introduction

Twenty years ago research on the relationships between domestic violence and culture was not acknowledged as being worthy of scholarly investigation. The prevailing beliefs supported race neutral approaches both for research and for practice and presented obstacles for those who wanted to examine the relationship between race, ethnicity, culture, and violence. It was not only difficult to obtain funding for research studies, but many peer reviewers for leading journals were not supportive of such research as well. Despite the growing literature on domestic violence, significant deficits remained in the research, theory, and practice for families and communities of color (Hampton & Yung, 1996).

Because many researchers and practitioners persisted in spite of the obstacles, a greater appreciation for interpersonal violence in communities of color, especially among African-American families, emerged in the late 1980s (Bell & Hill-Chance, 1991; Coley & Beckett, 1988; Hampton, 1987; Lockhart & White, 1989). One explanation for this was the realization that the disproportionate mortality and morbidity experienced in some communities of color was a direct consequence of violence. A primary contributor to the recognition perception of minority violence as a public health problem came from the Task Force on Black and Minority Health of the U.S. Department of Health and Human Services (USDHHS, 1985). Included in this report were studies that examined the link between violence and health outcomes (Hampton, 1986).

In this chapter, we describe what we know about violence in African-American families and review the research that suggests where we should

be focusing our efforts in the not too distant future. Specifically, we address the following questions: (a) What do we know about violence in African-American families; (b) What are the prevailing conceptual frameworks that might help us understand violence in the African-American community; and (c) What are some of the promising work being done in the field?

## What We Know About Violence in African-American Families?

The term domestic violence has had many meanings over the last 20 years. It is commonly associated with wife beating or spousal violence. In addition, it has been used to refer to a broad range of acts of interpersonal violence involving victims and offenders who are in some way related to one another. For example, domestic violence may refer to child abuse, sibling violence, intimate partner abuse, or even elder abuse (Gelles, 1997). Given that the primary focus of this chapter is on violence between men and women who are involved in an intimate romantic relationship, we have chosen to use the term "intimate partner violence" to characterize the specific relational context for the discussion that follows. The term intimate partner violence is generally used to refer to acts of violence that occur between current or former spouses, boyfriends, or girlfriends. Moreover, it tends to include violence between persons who have a current or former marital, dating, or cohabiting relationship (Tjaden & Thoennes, 2000).

African Americans are disproportionately represented among victims of intimate partner violence. One of the earliest sources of national data on the prevalence and incidence of intimate partner violence among African Americans are the two national family violence surveys conducted by Murray Straus and his colleagues. In both the First and Second National Family Violence Surveys, Straus and his colleagues reported that African-American males had higher rates of overall and severe violence toward their wives than did white husbands (Straus & Gelles, 1986; Straus et al., 1980). For example, in the second survey, African-American families self-reported higher rates of husband-to-wife violence (207 per 1000) than did white families (115 per 1000). This survey indicated that African-American marriages were at significantly greater risk for violence, with rates of severe assault 2.4 times than that of their white counterparts (Hampton & Gelles, 1994).

More recent studies report that African Americans experience higher rates of intimate partner violence compared to whites. For example, estimates from the National Crime Victimization Survey (NCVS) indicate that both African-American men and women were victimized by intimate partners at significantly higher rates than persons of any other race between 1993 and 1998 (Rennison & Welchans, 2000). African-American women experienced intimate partner violence at a rate 35% higher than that of

white women, and about 2.5 times that of women of other races. The National Violence Against Women Survey, a study based on "personal safety," found that African-American ethnicity was a significant factor in lifetime experience of interpersonal violence (Tjaden & Thoennes, 2000). A study of over 3000 women seen at emergency departments found that race (African-American) was among seven independent risk factors for a reported lifetime history of physical or emotional abuse (Dearwater et al., 1998).

African-American women in particular appear to be at disproportionate risk for experiencing intimate partner violence, especially black women, women aged 16 to 24, women with children under the age of 12, and women living in lower-income households. Thus, women who are more vulnerable to domestic violence tend to have less social, legal, and economic power (Robinson & Chandek, 2000a, 2000b).

Among male victims of intimate partner violence, African-American men experienced intimate partner violence at a rate about 62% higher than did white men and 2.5 times the rate of men of other races (Rennison & Welchans, 2000). For some, this raises questions about the extent to which there is abuse by both partners toward each other. When there is abuse by both partners toward each other, such incidents are known as reciprocal, mutual, or bidirectional abuse. Using data from the Army Central Registry of substantiated cases of interpersonal violence from 1998 to 2002, McCarroll et al. (2004) reported that African Americans and whites had about the same percentage of victims in nonmutual abuse cases and that there was a statistically significant difference in mutual abuse cases. There were 11% more African Americans (49%) than whites (38%) in mutual abuse cases. They felt that these data suggest that there may be some different dynamics operating in African-American households that should be examined further in order to develop appropriate intervention strategies. National data that describes the prevalence of intimate partner violence suggest that intimate violence tends to manifest a more reciprocal pattern among African Americans. This pattern of reciprocity is most evident in research that describes domestic disputes that culminate in domestic homicide (Goetting, 1991; Mann, 1996). A survey of murder cases disposed in the courts of eight large urban counties found that among African-American marital partners, wives were just as likely to kill their husbands as husbands were to kill their wives. For example, in cases of domestic homicide among African Americans, 47% of the victims were husbands and 53% of the victims were wives. In contrast, among white victims murdered by a spouse, 38% of the victims were husbands and 62% of the victims were wives (Dawson & Langan, 1994). Racial differences in the occurrence of domestic homicide may be partially related to the findings which indicate that African-American women are more likely to experience severe acts of husband-to-wife violence than are white women (Hampton & Gelles, 1994). Thus, the higher rates of severe, but nonfatal, acts of intimate partner

violence committed against African-American women may account for their greater representation among women who commit acts of victim-precipitated homicide (Goetting, 1991; Wolfgang, 1958).

Although several studies suggest that intimate partner violence may be more prevalent among African Americans than among whites, there is other data that suggest that social and economic factors probably account for much, if not all, of this apparent racial difference. Using data gathered through a purposive sample in a major southeastern metropolitan area, Lockhart (1991) argues that her data support the claim that African-American couples are not inherently more violent. Higher levels of violence, when they do exist, may be due in part to the particular social predicament of African Americans in American society.

In their analysis of data from the NCVS, Rennison and Planty (2003) found that when income, gender, and race are examined collectively, intimate partner violence rates differentiate along annual household income and gender, but not victim's race among black and white individuals. They argue that their analysis supports an economic rather than a racial explanation for victimization. Income inequities may be one factor explaining differences in rates of violence; however, controlling for income alone does not exclusively account for the racial disparity (Hampton & Gelles, 1994). In addition to income, there are several factors that constitute the structural context that contribute to the disproportionate rates of intimate partner violence among African Americans (Hampton et al., 2003). Rennison and Planty (2003) asked "is it the strain directly related to monetary resources available to the individuals or could a concentration of factors (e.g. poverty, drug use, unemployment, single parent family structures, aggressive policing) found in the communities where these individual lives produce the social context that increase the likely use and acceptance of violence as a means for settle disputes" (p. 441).

Carolyn West cautions us not to conclude that blacks are biologically or culturally more prone to violence than other ethnic groups (West, 2004). The elevated risk for violence is a consequence of being socially and economically disadvantaged. One explanation offered for the interrelationship among race, social inequities, and intimate partner violence is that some of the explanation of the risk of violence to women lies in larger social processes that lead some men and women into social settings that foster early school leaving, early family formation, and work histories that entail numerous spells of unemployment (Fox et al., 2002).

## Social and Structural Dynamics That Promote Intimate Partner Violence

Theories of domestic violence have tended to be crafted in a manner that ignores how racial or ethnic factors contribute to domestic violence. Consequently, theories specifically constructed to explain the etiology of

domestic violence in the African-American community are rare. In early theoretical works on the subject both Hampton (1980) and Staples (1982) argued that the institutional arrangements characteristic of American society contribute to intimate relationship conflict and domestic violence as a result of the manner in which African-American men have been deliberately denied equal access to educational and employment opportunities. That is, among scholars who have sought to explain domestic violence in the African-American community, many have suggested that the acts of violence African-American men commit against their wives and girlfriends do not occur in a social vacuum or are not merely acts of patriarchal domination and coercion. Rather, acts of intimate partner violence in the African-American community are very much influenced by the confluence of factors that have contributed to the subordinated status of African Americans in the larger society. The ritual expression of domestic violence among African Americans cannot be fully understood without consideration of the structural pressures associated with the legacy of being black in America (Hampton, 1980; Hampton et al., 2003; Staples, 1982; Williams, 1998). There are three distinct contexts in which intimate partner violence should be considered: structural, cultural–community, and situational (Hampton et al., 2003). What is significant about these contextual categories is that they reflect a macro–micro reductionism relative to the factors that influence situations and motivations in which black men batter their intimate partner.

## *Structural Context*

The term structural context is used here to refer to macrolevel structural arrangements and social conditions that have a direct effect on one's access to educational and employment opportunities and the pursuit of legitimate societal goals. The most important structural factor contributing to acts of violence perpetrated by African-American males is chronic frustration associated with their intergenerational exposure to racial and gender oppression (Madhubuti, 1990; White & Cone, 1998). A major feature of the experience of African-American men has involved coping with the challenges associated with institutional arrangements that have been designed to hinder their capacity to achieve political and economic equality with white men (White & Cone, 1998). The poor economic situation of African-American men has been adversely affected by race neutral transformations in the American economy that have led to widespread worker dislocation, particularly for those men who have traditionally sought employment in low-skill, high-wage, heavy industrial manufacturing industries, such as auto manufacturing (Wilson, 1996).

Chronic unemployment and underemployment among African-American men are having a negative effect on African-American women and children. For example, in 1998 nearly one in four (24%) African-American families had incomes below the official poverty level (U.S.

Census Bureau, 1999). One of the significant consequences of chronic unemployment and underemployment is that men who are afflicted by these social conditions are less likely to marry the mothers of their children (Wilson, 1996). In 1996 nearly half of all African-American families (47%) were headed by a single woman compared to 14% of white families (U.S. Census Bureau, 1999).

### *The Cultural–Community Context*

As a result of a combination of structural and community level factors many of the social supports that had constituted buffers against social oppression for generations of African Americans have eroded (Wilson, 1996). Consequently, within the social context of the local communities in which they reside in relative isolation from the conventional opportunity structure, many marginalized and nonmarginalized African-American males adopt and routinely construct alternative definitions of manhood. African-American men like some white men have been socialized to believe that to be a man is to be innately superior to women and that within the context of male–female relationships, men are supposed to dominate their wives and girlfriends (Hannerz, 1969; Liebow, 1967; Staples, 1982). However, African-American men have historically lacked the resources to institutionalize the subordination of women in the same manner as has been achieved by white men (Madhubuti 1990; White & Cone, 1998). Black men's dependence on the economic resources of working wives and girlfriends (Billingsley, 1992; Hill, 1999) has been characterized by Franklin (1984) as African-American manhood as a form of "subordinated masculinity."

This social construction of male identity has led to some African-American men to redefine manhood in a manner that is achievable within the realities of their unique social world. It has been suggested that such men generally adopt various manhood roles (e.g. the tough-guy/gangsta, the hustler, the player) as a means of compensating for their inability to achieve more acceptable manhood roles (e.g., the provider, the protector, the self-made man, etc.) (Anderson, 1999; Oliver, 2003). While these street-oriented masculine roles are adopted by many marginalized black men to compensate for their perceived shortcomings as sons, husbands, fathers, etc., in practice the behaviors associated with these roles are often dysfunctional compensatory adaptations because they compound existing social and psychological problems (Oliver, 2000). It is within this structurally induced cultural and community context that lower and working-class African-American women are at increased risk for becoming victims of intimate partner violence (Campbell et al., 2003). It is our view that African-American men who are frustrated by virtue of their exposure to historical and contemporary patterns of racial and gender oppression and who in response to such oppression adopt manhood roles that condone resorting to violence as a means of resolving disputes are at increased risk of

committing acts of intimate partner violence (Hampton et al., 2003). African-American women who reside in violent communities tend to be socially isolated as a result of their impoverishment and the social stigma associated with being black and poor (Stack, 1974). Consequently, these women tend to have limited access to adequate informal and formal sources of support and help when they experience intimate partner violence (Richie, 1994; Websdale, 2001; West, 1999; Williams, 1999).

### *The Situational Context*

Very little is known about the situational context in which acts of intimate partner violence occur in the African-American community. The situational context in which intimate partner violence occurs among African Americans is, in many ways, a product of the convergence of various structural forces (e.g., institutional racism, cycles of chronic under employment and unemployment, poverty, etc.) that constrict the lives of African Americans. While these adverse social conditions are an omnipresent feature of everyday life for many low-income and working-class African Americans, they are aggravated by the presence of African-American men who cope with their frustrations by defining manhood in terms of toughness, sexual conquest, and manipulation (Madhubuti, 1990; Wilson, 1996). Consequently, the frustrated masculinity of many African-American men along with their exposure to a cultural code that condones the sue of violence as a means of resolving conflicts with men and women (Anderson, 1999; Oliver, 1998) is a major factor contributing to disproportionate rates of interpersonal violence in the African-American community.

Economic dependence on one's wife or girlfriend is said to conflict with a man's perception of himself as the support, protector, and leader in the household (Ucko, 1994). Some men are motivated to commit acts of violence as a means of exerting control over an economically independent wife or girlfriend. In his discussion of why black men are angry, psychologist Ernest Johnson (1998, p. 11), who has provided counseling for many African-American men, has observed: "Because for most black men the definition of manhood includes their ability to hold a job, provide for themselves and a family, and successfully interact with the system. Most men will perceive a man who is not doing these things as failing his first test of manhood. These unsuccessful men may even hate themselves and others because of their circumstances and failures."

Alcohol and illegal drug abuse are often involved in encounters culminating in intimate partner violence. Kantor and Straus (1990) found that husbands' heavy drinking was associated with intimate partner violence among African Americans. Illegal drug use has become a significant risk factor in the occurrence of intimate partner violence among African-American women (Richie, 1994). In a survey of State prison inmates who had experienced abuse in the past, nearly 76% of abused men and 68%

of abused women reported that they had used illegal drugs (Harlow, 1999). African-American women who are involved in illegal drug use are at increased risk for experiencing intimate partner violence (Maher, 1997; Richie, 1994; Sterk, 1999). Women who are active drug users are often isolated from informal and formal sources of social support (Maher, 1997).

We also cannot ignore the disproportionate number of African-American males who have been involved with the criminal justice system, including many who have been in correctional facilities and who have returned to their partners and to their communities. Many of these men have had their views about the use of violence against women reinforced in these settings (Oliver & Hairston, in press; Tripp, 2003).

## What We Would Like to Know and What We Still Need to Learn?

Although there has been an increase in the amount of research focusing specifically on violence in families of color, there is still much work to be done. We know that there is a body of evidence that suggests there is an overrepresentation of African Americans as survivors and perpetrators of intimate partner violence and that various structural constraints and the collateral consequences emanating from these constraints may be a major factor. Because of the gaps that exist in our knowledge, however, there is much more that we would like to know and still need to learn if we are to significantly reduce the occurrence of intimate partner violence in the African-American community. For example, there are limited research findings that examine and describe the influence of ethnic and cultural background of survivors and perpetrators of violence and the subsequent influence on violence and traumatic outcomes (Humphreys et al., 2005). Similarly, when mandatory arrest policies were conceived there was no consideration of the potential unintended consequence of disproportionately incarcerating more perpetrator survivors in communities of color than in white communities (Bent-Goodley, 2005).

In recent years a number of domestic violence researchers and service providers have advocated for the need for racially homogeneous support groups for black victims and batterers (Williams, 1998, 1994). However, there are very few studies that have undertaken efforts to evaluate the effectiveness of racially homogeneous batterers interventions designed to serve African-American men who batter. Furthermore, very little is known about the various ways in which the family and friends of battered black women extend care and aid to victims of intimate partner violence. Nor do we know very much about the circumstances in which African-American women make decisions to disengage from abusive relationships (Taylor, 2002). The research on domestic violence in the African-American community consistently reports that cultural expectations often complicate how domestic violence is defined, as well as decisions to report abuse to the

police or to leave the relationship (Asbury, 1987; Few & Bell-Scott, 2002). Additionally, there is a need for research that explores the similarities and differences in the occurrence of intimate partner violence among lower, working, and middle-class African Americans. Finally, there is a need to explore the relationship between the high rates of community or street violence and intimate partner violence in the African-American community.

Nearly five million African Americans reside in rural America, yet there is nearly a complete lack of research that seeks to explain the social context and interpersonal dynamics of domestic violence among rural blacks (Williams, 2000). In addition, there is a need for prevention and intervention strategies that recognize the social and cultural realities of the rural black woman's experience.

## The Institute on Domestic Violence in the African-American Community (IDVAAC) Research Agenda

Since its inception in the mid-1990s the Institute on Domestic Violence in the African-American Community (IDVAAC; www.dvinstitute.org) has played an important role in fostering a dialogue amongst researchers, practitioners, and policymakers. Several important initiatives have emerged from the institute which has a bearing on expanding what we would like to know about violence. These initiatives by IDVAAC and others are attempts to bridge the gap between what we know and what we need to know about violence in the African-American community.

### *Community Assessments*

The family violence literature contains little information on how African Americans view domestic violence. Previous research focusing primarily on incidence and prevalence rates, program utilization, treatment complete rates, recidivism, and consumer needs tell the study of clinical outcomes, but do little to address the perceptions and cultural needs of African Americans experiencing violence (Williams & Tubbs, 2002). The absence of research on African Americans' perception of violence in their communities and its affects on their lives represents an important gap in our knowledge that has implications on multiple levels.

In 1998 IDVAAC launched a national effort to learn more about community perceptions of violence. The initial study, funded in part by the Office of Violence Against Women, focused on community perceptions of domestic violence of African Americans living in the San Francisco/Oakland, California, area. Since then, IDVAAC has conducted similar assessments in eight additional cities: Minneapolis and St. Paul, Minnesota; Seattle, Washington; Birmingham, Alabama; Philadelphia, Pennsylvania; Detroit, Michigan; Memphis, Tennessee; and Greenville, North Carolina.

The participants in each of the community assessments has included African-American community members representing a diverse group of stakeholders (e.g., criminal justice officials, child and youth service workers, domestic violence service providers, the faith community and representatives from the gay, lesbian and transgender community) who were involved in occupational activities that offer an insider's perspective about the impact of domestic violence in the African-American community. Two reports have been completed to date (Bent-Goodley & Williams, 2004; Williams & Tubbs, 2002).

IDVAAC'S community assessment research has examined issues ranging from community members' perceptions of causes and consequences for domestic violence to their perceptions of what should be done to reduce (prevent) violence in their communities. In these reports, researchers find the beginnings of questions warranting additional study, using either basic or applied research. For policymakers and researchers these reports reenforce the unquestionable need for their presence in the restorative process and the necessity for all stakeholders' input in the development of solutions with African-American community members.

### *Prisoner Reentry and Intimate Partner Violence*

According to data released by U.S. Department of Justice, in 2004, 61% of prison and jail inmates were racial and ethnic minorities (Harrison & Beck, 2005). An estimated 12.6% of all black men in their late 20s were in jails or prisons, compared to 3.6% of Hispanic men and 1.7% of white men in this age category. The disproportionately high rate of imprisonment among African-American men is one of the most significant challenges confronting African-American families and communities in contemporary America (Harris & Miller, 2003). However, little is known about the intersection of prison reentry and intimate partner violence and some scholars regard this as one of the missing links in both areas of research (Oliver & Hairston, in press). Given the disproportionate rate of imprisonment and postincarceration community reentry, clearly there are implications for families—including intimate partner violence. There is research which reports that incarcerated and paroled men experience significant levels of conflict with their intimate female partners during and following their incarceration (Tripp, 2003). However, this research does not examine the situational context and the interpersonal dynamics associated with acts of intimate partner violence involving returning prisoners or how returning prisoners and their partners attribute meaning to acts of intimate partner violence that occur during reentry (Oliver & Hairston, in press). Fortunately, there is research under way that is examining the intersection of prisoner reentry and intimate partner violence among African-Americans (Oliver & Hairston, in press; Oliver et al., 2004). Consequently, comprehensive prisoner reentry planning must include a programming

focus on intimate partner violence that is equal to the current emphasis on substance abuse, employment, mental illness, and housing, in addressing the public health and community safety implications associated with prisoner reentry.

## *Popular Culture*

Popular culture is an omnipresent, pervasive, and influential factor in the lives of African Americans (Boyd, 1997). Indeed, there is an ongoing debate about the role of black popular culture and its relationship to a variety of forms of interpersonal violence (e.g., gang violence, robbery, and dating violence) in the African-American community (Dyson, 1996; Kitwana, 2002). Although there has been considerable discussion about the various ways in which hip-hop culture glorifies overt displays of manhood and promotes misogyny, denigrates the image of African-American females, and possibly condones acts of intimate partner violence, (Kitwana, 2002; Morgan, 1999; Plough, 2004; Powell, 2003), insufficient research has been conducted to determine if there is an empirical association between exposure to and identification with hip-hop culture and intimate partner violence.

Carolyn West (2002) has argued that some of the images portrayed in hip-hop videos and the lyrical content of some hip-hop artists reenforce historically crafted images of black women. Some of these oppressive images, subtle or overt, contribute to the acceptance of beliefs (e.g., black women are promiscuous and immoral Jezebels, black women are aggressive, black women do not carry themselves in a respectful manner, etc.) used to normalize violence against black women. Furthermore, the broad dissemination of these stereotypes may lead criminal justice officials and domestic violence service providers to believe that black women are less credible victims of domestic violence (George & Martinez, 2002) and that violence directed toward them is justified (Gillum, 2002). West suggests that while these stereotypes are unpleasant and often minimized, researchers should explore how they influence personal and institutional responses to black women who are victims of domestic violence (West, 2004).

In contrast, to the point of view that black popular culture contributes to attitudes and beliefs that can support violence against women, there are those who believe that aspects of black popular culture can be effectively used to enhance awareness of intimate partner violence among African Americans and to facilitate secondary and tertiary treatment of domestic violence victims and batterers (Oliver, 2000). According to Oliver (2000), black gospel musical plays and black popular music has the potential to raise community awareness about domestic violence and to facilitate the prevention of domestic violence through their use as forms of "edutainment."

An innovative example of the use of popular culture to raise awareness about domestic violence in the African-American community is the "It's Your Business" program. This program is a radio-based, educational campaign that was designed by the Family Violence Prevention Fund to promote nonviolence in intimate relationships among African Americans (Mitchell-Clark, 1999). The campaign was designed to be culturally relevant by incorporating twelve 90-second segmented public service announcements in the form of radio talk show/soap-opera format. The cultural relevance of the "Its Your Business" program is the inclusion of characters, settings, and situations that reflect the "true to life" or ordinary realities and experiences of African Americans. The primary goal of this intervention is to change how the African-American community defines and responds to partner violence. This intervention should be evaluated so that we have a clear sense of its effectiveness and utility as a culturally specific approach to addressing African-American domestic violence.

## Conclusions

Current and future researchers, policymakers, practitioners, and others are certainly aware of the progress that we have made over the past 20 years in bridging the gap in our knowledge regarding intimate partner violence in the African-American community. To advance the field we must continue to think critically and creatively about our conceptual, frames of references, methodology, and our intervention/prevention strategies. In addition, we must be willing to use evidence, conceptual or empirical, to inform our practice. We must do so within the context created by the diversity within American society and within the African-American community. We must be willing to bridge the cultural waters and respond to issues with both cultural sensitivity and to the extent possible and willing to use evidence-based, conceptually sound approaches.

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# Chapter 2

# Young, Wounded, and Black*: The Maltreatment of African-American Children in the Early Years

Brenda Jones Harden and Sekile Nzinga-Johnson

The journey of African-American children to their current place in the child welfare system has been long and circuitous. During the nineteenth century, when many Western nations were wrestling with changing the way children were treated, African-American children were still subjected to slavery and later living under capricious laws such as Jim Crow. Laws and organizations established in the early twentieth century to protect children from harm did not pertain to African-American children. Thus, they were virtually neglected until more equitable policies were ushered in through the Civil Rights movement and its aftermath (Billingsley & Giovannoni, 1972; Chipungu, 1991).

In stark contrast to the neglect of African-American children by the child welfare system that existed half a century ago, African-American children are currently *overrepresented* in this service sector (see Courtney & Skyles, 2003). In other words, they are more likely to be involved in the child welfare system than what would be expected by their proportion of the population. Some scholars assert that the overrepresentation is due to the large number of young African-American children who enter the child welfare system and do not exit. In fact, some research has documented that the expedited adoption of young African-American children has significantly reduced this overrepresentation across the nation as well as in specific jurisdictions (Wulczyn, 2004). It also stands to reason that if the maltreatment and foster care placement of young African-American

* Adapted from title of song by Nina Simone "Young, gifted and black."

children could be prevented, then some of the racial disparities that have been observed in the child welfare system could be abated.

Interestingly, child welfare research has also documented distinctions in child welfare experience relevant to age. Young children, below the age of 5 years, are also overrepresented in the child welfare system. The vulnerability of young children to the adverse sequelae of maltreatment and of being in the child welfare system has been documented (see Clyman & Jones Harden, 2002; Silver et al., 1999). Specifically, the younger a child is, the more likely s/he is to be maltreated, placed in foster care, have longer durations in foster care, and exhibit more profoundly detrimental consequences due to these experiences. It is critical that the child welfare service sector establish a programmatic and policy agenda that prevents the maltreatment of this specific population of children.

Thus, young African-American children represent a particularly unique population of children in regard to the child welfare service sector. They are overrepresented in the child welfare system based on two factors—their age and race. Perhaps due to these factors, they are also more likely to be negatively affected by their child welfare experience. This chapter identifies strategies to prevent the maltreatment of young African-American children, and as such prevent their entry into the overburdened child welfare system. As such, it provides an epidemiologic and developmental profile of these children and their families, in order to understand their unique needs and how these should inform program development. Further, it delineates prevention and treatment programs that have found to be effective with this population and describes culturally and developmentally sensitive interventions that have the potential to prevent their maltreatment and placement into the child welfare system.

## Profile of Young African-American Children in Child Welfare

### *Racial Disparities*

The overrepresentation of African-American children in the child welfare system has been extensively documented (Barth et al., 2001; Courtney & Skyles, 2003; Courtney et al., 1996; Morton, 1999), despite evidence pointing to equivalence in the rates of maltreatment across racial/ethnic groups (see Sedlak & Broadhurst, 1996). National data indicate that over one quarter (26.1%) of substantiated maltreatment victims (i.e., identified by the child welfare system following a report) are African-American compared to 54.2% of victims who are of the Caucasian race (ACF, 2004). Next to Native American children, African Americans have the highest rate of maltreatment victimization at 20.2 per 1000 children, which is twice the rate for Caucasian and Hispanic children (ACF, 2004). Other studies (e.g., Wulczyn, 2003; Wulczyn et al., 2002) support these findings

and suggest that the racial differences are even more apparent in urban areas. Interestingly, African-American children are far less likely than Caucasian children to experience a recurrence of maltreatment (ACF, 2004).

A plethora of evidence has revealed that African-American children have different trajectories through the child welfare system. African-American families are more likely to be substantiated for maltreatment, even when the presenting issues are similar to those faced by families of other racial/ethnic groups (Levine et al., 1996; Lu et al., 2004; Rolock & Testa, 2001). They are also more likely to be placed in foster care (ACF, 2005; Needell et al., 2003), and have longer durations in care (Schmidt-Tieszen & McDonald, 1998; Wulczyn et al., 2001). In terms of their exits from care, they are less likely to be reunified with their families (Wulczyn, 2004; Wulczyn et al., 2001) as well as less likely to receive in-home services (Courtney et al., 1996; Garland & Besinger, 1997). Although they still have lower adoption rates than children of other racial/ethnic groups, there is some evidence that the adoption of African-American infants is on the rise (Barth, 1997; Courtney & Wong, 1996; Wulczyn, 2003).

While in the foster care system, African-American children have different experiences than their Caucasian counterparts. They are more likely to live with relative caregivers, particularly in urban areas (Geen, 2004; Wulczyn & Hislop, 2002). They also receive fewer services than their Caucasian counterparts, such as mental health intervention (Garland & Besinger, 1997; Garland et al., 2003; Landsverk et al., 1996). It should be noted that although the disparities between African-American and Caucasian children still exist, it appears that the gap in terms of placement rates has narrowed somewhat in the last few years (Wulczyn, 2003). This has been attributed to the increasing adoption rates for African-American children.

### *Age Differences*

Evidence from multiple recent studies has revealed that young children, particularly infants, are more likely to be involved in the child welfare system. National administrative data have indicated that maltreatment victimization rates are inversely related to age (ACF, 2004). In 2002, the rate of child maltreatment for 4 to 7-year-olds was 13.7 per 1000, for birth to 3-year-olds was 16.0 per 1000. Children 3 years of age and younger were most likely to be maltreated, with those less than 1 year of age comprising almost 10% of all child maltreatment victims nationally (ACF, 2004). Evidence from smaller studies suggests that infants are 3–5 times more likely to be maltreated than older children (Wulczyn et al., 2002). Infants younger than 1 year of age have a maltreatment rate that is twice the rate of the overall maltreatment rate (Wulczyn et al., 2002). Children less than 4 years old are also more likely to be subjected to maltreatment recurrence. For example, data from the Multi-State Data Archive place the recurrence rate for infants at 14% (Wulczyn et al., 2002).

Age disparities also exist in the rates of foster care placement. Over one quarter (29%) of the children in foster care are 5 years of age or younger (ACF, 2005). Young children account for a high percentage of "new entries" into foster care. For example, in 2002, 40% of children who entered care were 5 years of age or younger (ACF, 2005). In urban areas, half the infants whose maltreatment is substantiated will experience foster care placement (Wulczyn & Hislop, 2002). Infants also remain in foster care longer than any other age group (Wulczyn et al., 2002). They are also the population who is mostly likely to be adopted (Wulczyn et al., 2002). Of the 40% of infants who exit foster care through reunification with their biological parents, 1 out of 5 will return to foster care, often within 90 days (Wulczyn et al., 2002).

### *Maltreatment Experiences*

As stated previously, young children have a much higher likelihood of being maltreated. Approximately half of these children are neglected, and another quarter experience physical abuse (ACF, 2004). In the majority of cases, substance abuse is a major precipitating factor for maltreatment (Jaudes et al., 1995). Many young children are identified as maltreated, not because of their direct victimization but because of their exposure to family violence. The high co-occurrence of child maltreatment and domestic violence (Appel & Holden, 1998; Edleson, 1999) has been offered as a reason for this trend. These families tend to live in poverty, have large number of children, and experience extensive stress, substance abuse, and mental health problems (Hartley, 2002). They are also more likely to have a male parent or caregiver in the home, who often has a history of substance abuse, mental health problems, or nondomestic violence-related offenses (Hartley, 2002). Thus the children in these families experience "double exposure" to violence, through direct and indirect victimization (Jones Harden & Koblinsky, 1999).

Although the maltreatment experiences of young African-American children are similar to their Caucasian counterparts (Medora et al., 2001; Sedlak & Broadhurst, 1996), their child welfare experiences may be somewhat different. For example, the NSCAW study suggests that African-American children may be less likely to have an open child protection case although they may be experiencing severe violence in the home or may have been exposed to sexual abuse (Barth, 2003). It has been demonstrated that African-American children and families receive fewer in-home family support services and mental health services, although their needs are no less than children and families of other racial/ethnic groups (Garland & Besinger, 1997). Thus, preliminary evidence suggests that child welfare services provided to young African-American children and their families are much more limited.

## *Consequences of Maltreatment*

Although African-American children represent a resilient group that has overcome many odds to adapt to the American mainstream culture, their development is still globally compromised. They have been found to have worse physical and mental health outcomes than their Caucasian counterparts (National Institutes of Health, 2002). Additionally, their cognitive and academic skills consistently lag behind other groups of children (U.S. Department of Education, 2000). Scholars have attributed these phenomena largely to poverty and related factors, given that African-American children are disproportionately likely to be poor in this country (McLoyd, 1998).

The experience of maltreatment, and perhaps even of foster care itself, exacerbates the negative impact of poverty and minority status on African-American children's functioning. The developmental outcomes of maltreatment are not just the result of the abuse or neglect itself, but can be attributed to a wide range of factors associated with the risk of problematic parenting (Rogosch et al., 1995b). Genetic factors, prenatal experiences, individual child characteristics such as temperament, parental psychopathology, other family influences such as social support, and larger environmental risks such as poverty all play a role in determining the development of children (Bronfenbrenner & Ceci, 1994; Cicchetti et al., 2000). The complex interaction of these factors with the maltreatment and specific child welfare experiences may lead to a variety of negative sequelae in young children across developmental domains.

In the physical domain, young abused children suffer a variety of injuries specific to the type of abuse they receive. For example, infants who are diagnosed with shaken baby syndrome may experience neurological abnormalities secondary to intracranial injuries, such as motor deficits, cerebral palsy, paralysis, impaired growth, developmental delay, and mental retardation (Smith, 2003). They may also suffer ocular damage (e.g., retinal hemorrhage, visual loss, blindness). Similarly, young children who are victims of physical assaults may have broken bones, bruises, and burns that are the physical manifestations of abuse, as well as neurological damage (Jaudes & Bilaver, 2004). Physical abuse is more likely to result in fatalities for young children. Evidence from the National Child Abuse and Neglect Data System (ACF, 2004) indicates that 41% of the fatalities resulting from child maltreatment occur in infants under 1 year of age. In fact, the Centers for Disease Control lists nonaccidental head trauma as the leading cause of death in infancy.

Although sexual abuse is not common in young children under 5 years of age, the consequences for them may be more detrimental than they are for older children. Young children may contract sexually transmitted diseases (STDs) and infections as a result of sexual interactions with adults (Hegar & Emans, 1992). It should be noted that neonates can be exposed

to STDs during the delivery process as well. For example, although the number of pediatric HIV and AIDS patients has decreased due to rigorous medication regimens provided to pregnant women, infants in the child welfare system continue to have high rates of HIV exposure (American Academy of Pediatrics, 2000).

The neglect of young children may also result in adverse physical outcomes. Failure to thrive (FTT) is often diagnosed in children who are neglected, by parents who fail either to feed their children or to provide emotional sustenance (Black et al., 1995). Either precipitant can lead to growth delays in young children, specifically height, weight, and head circumference below the fifth percentile. Neglect of young children also is associated with the increased incidence of childhood diseases, such as respiratory problems, ear infections, and lead exposure (Dubowitz, 1999). Similarly, neglected children receive poorer medical care and thus often have untreated illnesses (Dubowitz, 1999; Jaudes et al., 1995).

Advancements in brain research have provided new knowledge regarding the impact of maltreatment on the developing brain. This line of research is essential to consider when examining young children given that the bulk of brain development occurs during the first 5 years of life (Byrnes, 2001; Nelson & Bosquet, 2000). For example, the brain is 90% of its adult weight by the time a child is 5–6 years old. The process of synaptic overproduction and pruning, which is strongly related to how children adapt to their environment, transpires predominantly during the infancy period (Fox, 1994; Nelson & Bosquet, 2000). Brain research suggests that maltreatment experiences have an impact on brain structures and processes that give rise to a number of psychological difficulties (Kaufman & Henrich, 2000).

For example, the impact of trauma on the brain has been associated with cognitive delays, poor self-regulation, and attentional difficulties (DeBellis, 2001). Impaired memory, dissociation, hyperarousal, and elevated fight/flight responses have been documented in abused children and linked to trauma's effects on the emotion centers of the brain (Perry et al., 1995). Other studies have implicated altered hormonal processes in the impact of trauma on psychological functioning, specifically self-regulation (Gunnar & Davis, 2003; Gunnar et al., 2001; Hart et al., 1995).

Findings relevant to the impact of neglect on young children's brain functioning have emanated mainly from studies of children who were reared during their early years in institutions (Zeanah et al., 2003). Children in these extremely neglectful environments receive less sensory stimulation and nurturance (e.g., touching, affection). This sensory and affective deprivation leads to impaired brain functioning, which may explain some of their cognitive delays and asocial behavior (Rutter et al., 2004). Research in two other areas speaks to the impact of neglect on the developing brain. Studies of the impact of maternal depression suggest that

the affective deprivation that children of depressed mothers experience leads to reduced brain activity and associated cognitive and social deficits (Dawson et al., 1994). Additionally, prenatally drug-exposed children may have alterations in their central nervous systems that render them hyperactive and distractible (Frank et al., 2001; Singer et al., 2002).

Perhaps due to the many biological and environmental factors associated with child maltreatment, a large proportion of victimized children have cognitive delays. The recent National Survey of Child and Adolescent Well-being (NSCAW; ACF, 2003a), the first nationally representative study of children in the child welfare system, documented that over half (53%) of maltreated infants screen positive for development delay (e.g., cognitive, language, and motor skills). Approximately one third of preschool maltreated children in the NSCAW study evidence cognitive developmental delays. These cognitive delays have been documented to be related to deficits in the social–emotional realm (Rogosch et al., 1995a). Language deficits have also been documented in maltreated children. Fourteen percent of preschoolers in the NSCAW study display delayed functioning in their language skills (ACF, 2003a). Other studies have documented specific language delays in terms of the complexity of the lexicon and grammatical structure of language (Coster & Cicchetti, 1993; Coster et al., 1989; Eigsti & Cicchetti, 2004). This is a particularly wide-reaching consequence of maltreatment that has long-term effects on these children's later literacy and academic functioning.

By far, the majority of research on the consequences of maltreatment has been conducted in the social-emotional realm. Neurobehavioral deficits have been documented in young maltreated children, particularly in those exposed to physical trauma and prenatal drug exposure (Jaudes & Bilaver, 2004; Singer et al., 2002). Symptoms of posttraumatic stress disorder have also been documented (Scheeringa & Gaensbauer, 2000). Although young children exhibit different specific symptoms than older children and adults, the hallmarks of traumatic stress are evident in young children, such as hyperarousal, dissociation or psychic numbing, and reexperiencing of the traumatic event. Interestingly, some research has documented that the relationships young children have with their caregivers are salient predictors of traumatic stress symptomatology in this population (Scheeringa & Zeanah, 2001).

Attachment theory has undergirded much of the research and practice relevant to maltreated children. Multiple studies have documented that young maltreated children have less secure attachments than their nonmaltreated counterparts. The majority of maltreated children are classified as *disorganized*, which is considered the most insecure attachment type (Lyons-Ruth & Jacobvitz, 1999; Lyons-Ruth et al., 1991). Some research suggests that abused children are more likely to exhibit an *avoidant* pattern and neglected children a *resistant* pattern of attachment (Egeland & Sroufe, 1981; Youngblade & Belsky, 1990). Many scholars have suggested

that maltreated young children are much more likely to exhibit attachment disorders (Zeanah et al., 2004).

Maltreated children tend to have core deficits in the areas of self- and emotional development (Kaufman & Henrich, 2000). A small body of research has suggested that maltreated children have negative self-images and exhibit negative affect when looking upon themselves (Beeghly & Cicchetti, 1994; Toth et al., 1997). They are more likely to have emotion recognition and processing difficulties as well (Pollock et al., 2000). Although they perceive moral dilemmas similarly to their nonmaltreated peers, maltreated children display more negative affective reactions to moral situations (Smetana et al., 1999). They also tend to have emotion regulation difficulties and exhibit elevated rates of internalizing and externalizing behavior problems. For example, in the NSCAW study described previously, approximately one quarter of young children (2 to 3-year-olds) reached the clinical range for behavior problems (ACF, 2003a).

## Evidence-Based Intervention for Young African-American Children and Families

The overarching purpose of this volume is to identify interventions to address interpersonal violence within the African-American community. It should be stated at the outset that few studies have targeted African-American children. Moreover, evidence-based interventions that are framed by knowledge specific to the cultural characteristics of African Americans are basically nonexistent. The previous epidemiologic and developmental profiles are informative for developing interventions to prevent maltreatment as well as to promote the development of young children and their families. However, interventions linked to these data are virtually absent from the practice and empirical literatures.

Following is a description of prevention and treatment programs that have been conducted with samples that have included large proportions of young African-American children and families. Evidence-based programs that have been found to be effective with this population are the focus of this discussion. This section is concluded with a delineation of promising practices (i.e., those that have not been rigorously evaluated) for young African-American children and families that have been suggested by the theoretical, conceptual, intervention, and empirical literatures relevant to the African-American culture.

### *Prevention Programs*

Scholars have argued that the most effective prevention programs are initiated early in the lives of children, or even in the transition to

parenthood (MacLeod & Nelson, 2000; Olds et al., 2000). Thus, programs beginning in the prenatal period and during the early years of childhood have been found to be effective in reducing rates of child maltreatment, altering family characteristics that are associated with maltreatment, and promoting the well-being of young children and families. National, evidence-based prevention programs are described as well as smaller studies of more targeted interventions. The results of these evaluations are mixed, with the more theoretically driven, targeted programs being more likely to produce benefits for children and families.

*Healthy Families America* (HFA) is perhaps the largest national program with a goal of preventing child maltreatment. HFA is basically a home-visiting program that spans the prenatal or immediate postnatal period through age 5. Services are comprehensive and they focus on the young child in the context of the family. Because of its scope as a national program, Healthy Families interventions have been employed with African-American populations in many locations. However, the programs that have been rigorously evaluated are in locales with very limited African-American populations (e.g., Hawaii; Duggan et al., 2004a, 2004b). The randomized trial in San Diego, CA, did include some African-American families, but showed no effects (Landsverk & Carrilio, 2004). Several quasi-experimental evaluations of this model have been conducted in locales with larger populations of African-American families. Some of these studies have reported reductions in child maltreatment reports. However, many are fraught with methodological and attrition challenges (see Duggan et al., 1999), which call into question their findings.

Perhaps the most often-cited prevention program is the *Nurse Family Partnership*, a home-visiting program targeted toward high-risk, primiparous mothers and their young children. This program reduced maltreatment with a high-risk, semirural, largely Caucasian sample (Olds et al., 1986, 1997). When the model was implemented in Memphis, TN, with a predominately African-American sample, maltreatment effects were not documented per se (Olds et al., 2000). Reductions in health care encounters and hospitalizations for injuries and ingestions for intervention children were documented, which the authors suggested could reflect a decrease in child maltreatment incidents.

*Project Safe Care* is another home-based preventive intervention for families at risk of maltreatment of their young children. Social workers or nurses administer the intervention using videos, parent education, and skill practicing. They focus on three areas: home safety, infant and child health care, and bonding and stimulation. Preliminary results of the evaluation of this program include increased parental interaction with children, decreased household hazards, and increased knowledge of child health problems (Lutzker et al., 1998; Lutzker & Bigelow, 2001).

In another study of a home-visiting intervention (Black et al., 1994), trained nurses provided biweekly home visits for a 2-year period to low

SES, drug-abusing mothers in Baltimore, MD, with a majority African-American population. At follow-up, mothers in the intervention group were less likely to report ongoing drug use, were more likely to complete pediatric appointments, and exhibited greater emotional and verbal responsiveness to their infants. Gelfand et al. (1996) also used nurses to provide home visits to depressed mothers during their infants' first year of life. Mothers in the treatment group exhibited fewer depressive symptoms and daily hassles than those in the control group. Additionally, control group mothers reported fewer social supports over time, and if they were depressed, became more punitive toward their children over time. In contrast to these two studies, Marcenko et al. (1994, 1996) did not find that the goal of reducing child out-of-home placement was met in a home-visiting program serving primarily African-American mothers experiencing psychiatric illness, substance abuse, or domestic violence. However, intervention mothers reported less psychological distress and more social support over time; control mothers did not report these changes.

Parenting programs have yielded some positive results. In the majority of such programs, abusive parents are trained in behavioral management techniques. Studies have documented improved parental capacity to manage anger/aggression and reductions in the use of physical discipline (Kolko, 1996; Schinke et al., 1986). Wolfe et al. (1988) provided a behaviorally oriented parenting education program for abusive families with preschool age children. Intervention parents reported fewer child deviant behaviors and maternal adjustment difficulties. Additionally, families' caseworkers reported reduced risk for child maltreatment in intervention families. However, differences were not found when observers examined the home environments of participant families versus nonparticipant families.

Comprehensive child development programs have also been found to reduce maltreatment. A large longitudinal investigation of Title I Child–Parent Centers in Chicago, IL, included many African-American children and families. This very rigorous evaluation documented a lower rate of child maltreatment, via court petitions and child protective service records, for intervention children than for children who received kindergarten intervention (Reynolds & Robertson, 2003). This finding held throughout childhood and adolescence, and was more pronounced if the children had received 4–6 years of intervention.

### *Treatment Programs*

Treatment programs are designed to improve outcomes for families in which maltreatment already exists. Similar to the prevention literature, few interventions have been designed to address specifically the African-American culture. As such, treatment interventions that have been conducted with African-American families are presented. Although traditional individual and family treatment approaches still exist, the

following discussion focuses on more recent treatment models for young children and families experiencing maltreatment that have moved beyond traditional therapeutic approaches to more dyadic and group models.

In a program for mothers at risk for attachment disorders, infant–parent psychotherapy was provided in the home for 1 year (Lieberman et al., 1991). Although intervention dyads were not more likely to be securely attached than controls, they engaged in more frequent partnered interaction. Additionally, mothers in the intervention group expressed greater empathy toward their children and communicated more frequently with them. Infants expressed less anger, demonstrated less avoidance, and were less resistant to maternal requests.

An evaluation of a program serving high-risk mothers in Los Angeles, many of whom were African-American, examined the effects of a combination home- and clinic-based program. The study found that mothers receiving the intervention were less likely to be restrictive and punitive and more likely to promote their infants' autonomy (Heinicke et al., 1999, 2001). Their infants were less likely to be insecurely attached, were more likely to perceive themselves as autonomous, and demonstrated greater expectations that their needs would be effectively met.

Recently, scholars have begun to examine the effectiveness of therapeutic programs for foster families and the young children living in their care. For example, Zeanah et al. (2001) developed an intervention in New Orleans, LA, that served African-American children and families. The intervention incorporated comprehensive assessment and infant–parent psychotherapy regarding parent–child relationships. They evaluated the impact of this preventive intervention with infants and toddlers in foster care on their child welfare outcomes. Fewer intervention children were reunified with their biological parents and more were freed for adoption than those who did not receive the intervention.

A pilot cognitive-behavioral intervention yielded positive outcomes for preschool children requiring treatment foster care due to emotional difficulties. Because the sample size for the entire project was small, only a small number of African-American children were included. The intervention consisted of intensive behavioral parent training, intensive support and supervision, a weekly support group, and 24-hour crisis intervention for foster parents. The children received services from behavior specialists in their day-care centers, homes, and a weekly playgroup. The authors suggest that this intervention may have an impact on foster parent functioning (e.g., provide more positive reinforcement to children) and child behavioral outcomes (Fisher et al., 2000).

## *Culture-Specific Programs*

Although the following intervention was not intended to prevent maltreatment or to address the needs of young children, it is being included in this section because it is possibly the only evidence-based prevention

program to date that has specifically employed a culturally based design to prevent negative parenting processes and negative child outcomes in African-American families. The *Strong African-American Families Program* (SAAF) is a preventive intervention for African-American parents and their preadolescent children who reside in a rural, southern area (Brody et al., 2004). The overarching goal of the intervention is similar to the general goals of maltreatment prevention programs—to modify the parenting processes that are pertinent to positive child outcomes. Specifically, this program attempted to have an impact on parents' involvement with, socialization of, communication with, and expectations of their children. The evaluation of the intervention demonstrated its effectiveness in modifying parenting processes, and ultimately promoting child protective factors (i.e., negative attitudes about alcohol/sex, acceptance of parental influence, future orientation). Important features of this program were its theoretical and empirical foundation, developmental and cultural sensitivity, and methodological rigor of the evaluation.

The application of the aforementioned features to a preventive intervention for African-American families at risk of maltreating their young children is essential from scientific and practice perspectives. Moreover, it has the potential of stemming the tide of young African-American children who are coming into the American child welfare system. In order to implement such programs, an understanding of the literature on African-American families is imperative. We now turn to a consideration of this literature, and how the evidence informs the development of maltreatment prevention programs for African-American families with young children.

## African-American Cultural Processes and Opportunities to Intervene

Many African-American scholars have advanced theories that suggest African-Americans' cultural connection to Africa and their legacy of resistance and survival in the United States distinguish them as a unique cultural group (Boykin, 1983; Boykin & Toms, 1985; Hill, 1972, 1998; Nobles, 1974; Peters, 1986; Stevenson, 1994, 1995, 1996; Wilson, 1986, 1989). Collectively, these scholars assert that African Americans should have access to cultural-specific interventions and should be investigated independently of other groups in order to capitalize on the processes within the African-American community. To date, child welfare programs have not fully examined or used this richness to create programs that are inclusive and respectful of African-American families.

Scholars have long advocated for the elevation of cultural competence as a prerequisite for programs concerned with improving the outcomes of minority children and families. "The question is no longer one of 'whether' to provide culturally competent services to clients, but rather 'how' can

we do it best" (Asamoah, 1996, p. 1). Designing culturally responsive interventions with guidance from ethnic communities promotes the development of culturally responsive services. Facilitating the inclusion of the ethnic communities' thoughts and recommendations strengthens practice models and their effectiveness. Although many of these issues have been raised in the field for close to 30 years, there continues to be a dearth of empirical data and group-specific practice literature on African-American-centered practices.

According to Taylor (1991), ignoring cultural diversity can lead to distortions and ill-founded conclusions about child-rearing practices. The root for such distortions is an ethnocentric approach in which professionals use standards from their own cultural background to judge and to make conclusions about people from other cultures (Brislin, 1990). Many studies have documented a relation between culture/race/ethnicity and child-rearing practices (e.g., Ferrari, 2002; Garcia Coll, 1990). Therefore, in situations of child maltreatment, assessments and interventions that consider cultural dimensions could prevent such distortions.

### *Structure, Functions, and Roles in African-American Families*

Parents play an integral role in fostering competencies in minority children (Garcia Coll, 1990; Harrison et al., 1990; McAdoo, 1982; Wilson, 1984, 1986, 1989). Super and Harkness (1986) argue that parents of different cultures possess parental cultural belief systems or ethnotheories that structure their caregiving environments and guide their parenting processes. For many minority families, child outcomes are often moderated by the presence of other extended family members within their caregiving environments. For example, Marshall et al. (2001) found that although White, African-American, and Hispanic families all were connected to their social worlds at varying levels, the African-American participants in their study were more likely to interact with their immediate and extended family surrounding care for their children more often than the other two groups. This style of shared parenting and social support addresses many of the needs faced by parents in many minority communities. Child welfare agencies must continue to create alliances with this indigenous form of social support of their African-American consumers.

African-American families have long been characterized as largely relying on their extended family networks as their primary social supports. However, there has been considerable debate among scholars as to whether this form of social support is a cofactor of poverty in ethnic minority families or whether it is an expression of African-American cultural traditions (McAdoo, 1992). However, multiple studies have documented that African-American families rely on extended family members for support regardless of social class (Hill, 1999; Landrine & Klonoff, 1996; McAdoo, 1993). The increased number of maltreated children who are diverted from

the child welfare system through kinship placements (i.e., relative custody, guardianship, foster care, and adoption) provide compelling evidence of this phenomenon as it relates to the care of African-American children (Geen, 2004).

Recent research with African-American families reminds us that social support, not family structure alone, has implications for more responsive parenting (Brody et al., 1994b; Burchinal et al., 1996). In fact, some studies of adolescent mothers in multigenerational households have revealed more conflictual relationships with their coresident mothers (Black et al., 2002; Black & Nitz, 1996) and possibly poorer parenting skills in adolescent mothers in some extended family households (Gordon et al., 2004). This line of evidence suggests that although many African-American parents may rely on extended family for social support, the availability and reliance on such supports may vary according to demographic, situational, and individual parameters (Crockenberg, 1981; McAdoo, 1978). The vulnerability of the kinship family systems of maltreated children (Clyman et al., in press; Geen, 2004) also suggests that extended family support is not a panacea, but could be bolstered by other community supports for vulnerable families.

A culturally responsive and empowering use of the extended family in child welfare is the *family group conference*. This promising practice, which originated in New Zealand, was adapted for use in North American minority groups, including rural and urban African Americans. The North Carolina Family Group Conferencing (NC-FGC) Project (Pennell & Weil, 2000) attempted to increase the level of cultural competency in child welfare services across the state by incorporating a collaborative model that validates the importance of the family's knowledge, skills and cultural values regarding the well being of its children. Specifically the family conference aims to provide the larger family group with an opportunity to develop a plan to resolve the child welfare concerns and deprofessionalize child welfare decision making while safeguarding the interests of the child(ren). Multistate implementation studies have found that families come to meetings when invited, they develop plans that practitioners were appreciative to endorse, and were satisfied with the process and the result (Pennell et al., 2002).

In the developing stages of the program, African-American samples participated in focus groups. The data revealed that they perceived the model in a positive manner because of its inclusion of family traditions and the celebration of culture. They strongly connected to the model's potential use of spirituality, singing, and praise as part of the techniques to foster family growth. Additionally, they pointed out that traditions and rituals as components of the approach would be meaningful to black families. They particularly appreciated having extended family members included in the decision-making process and wanted decision-making power

to be removed from Departments of Social Services. They felt that all these elements were crucial in creating an environment conducive to productive planned change.

Outcome evaluation of the family group conferencing model demonstrated promising results. For example, there was evidence that children were more likely to be maintained in their families, kin, or cultural groups. Children's out-of-home placements were more stable and rates of child maltreatment decreased. Families also reported greater feelings of family pride ("Promising Results," 2003). Thus, the preliminary evidence relative to this practice suggests that the approach is empowering to both the family and the larger African-American community, and results in positive child welfare systemic outcomes.

*Communalism* is another cultural tradition that has been found to characterize the African-American population (Chipungu, 1991). From this perspective, the traditional boundaries of child welfare (i.e., professional as child protector; limited role of community) must be loosened in order to capitalize on the interconnectedness of the African-American community. The current redesign of many child welfare services to become more community-centered has to a great extent capitalized on this communalism. The overall goal is to strengthen and support resilient communities, which in turn support families. An intervention study conducted by Mosby et al. (1999) attempted to rebuild and strengthen community ties by pairing elders as mentors with parents at a local agency. The research phase of the project recorded and analyzed the African-American elders' views on parenting and discipline. Findings suggest that although both parents and mentors reported an endorsement of corporal punishment, the elders/mentors articulated a strong opposition to cursing and screaming at children. They further articulated that without the proper combination of nurturing, teaching, and physical discipline, children have not been "raised." Finally, they decried the physical discipline that was increasingly being used in anger and without the "teaching" they felt must accompany it. Given this widely accepted cultural difference in parenting, the authors suggest that child physical discipline should not be seen as deviant. Instead, studies such as these advocate fully examining the purpose, context, frequency, and intensity of physical discipline in concert with examining African-American children's functioning and development.

## The Role of Fathers: Untapped Family Resources

In addition to the role of the extended family, the role of fathers in child welfare interventions is grossly undervalued. In contrast with earlier literature about African-American fathers that ignored their presence altogether in the lives of their children or emphasized pathological

characteristics (Allen, 1981; Bowman, 1985; Cochran, 1997; McAdoo, 1981), a growing body of literature identifies this group as contributing to the well-being of their children (Cazenave, 1979, 1984; Fagan, 1996; Hendricks, 1981; Hunter & Davis, 1994). Though they have been largely omitted from child welfare interventions and research, they prove to be an underutilized natural resource available to children at risk of maltreatment. A study by O'Donnell (1999) explores the extent to which African-American fathers have been involved in services to children and families involved in child welfare agencies, the roles that fathers have played in interventions, and the outcomes of paternal involvement. The findings suggest that there was extensive absence of and silence about fathers in the cases reviewed, which in turn suggests system deterrents to paternal involvement. In addition, caseworkers' perceptions of and attitudes toward fathers as well as agency expectations about casework with fathers appeared to have played a role.

The findings from O'Donnell's (1999) work have direct implications for child welfare practice and policy. Specifically, practitioners who consider working with African-American fathers must be sensitive to the detrimental effects of socioeconomic forces on African-American men in order to help these fathers overcome the psychological barriers that may affect their ability to care for their children (Bryan & Ajo, 1992; Tamis-LeMonda & Cabrera, 2004). Findings from other studies of father involvement (e.g., Early Head Start) suggest that African-American fathers are playing an increasing role in the rearing of their young children. Due to the unfortunate consequence of maternal substance use, many fathers are experiencing new found opportunities to parent. With support, many can become competent and involved parents of their young children (Cabrera et al., 2004; Tamis-LeMonda et al., 2004).

### *Spirituality and Religion and Family Functioning*

Over the years, African-American scholars have encouraged the investigation of the effects of religion on family processes (Hale-Benson, 1986; Hill, 1972). The significance of religion and spirituality in African-American families has been well documented in the literature (Brashears & Roberts, 1996; Hill 1999; Nobles, 1974). African Americans have been characterized as being a deeply spiritual and religious group. When compared to whites, African-American families consistently manifest higher levels of religiosity (Hill, 1999; Taylor, 1988; Taylor et al., 1986). For instance, recent studies have found that in 1991, 81% of African Americans were church members (Brashears & Roberts, 1996). Additionally, the National Urban League Black Pulse Survey (Hill & Wornie, 1993) found that two-thirds of African Americans attend church weekly or several times a month and that 70% of African-American parents send their children to Sunday school.

Findings from a recent study found that African-American parents were significantly more likely than the white parents in the study to rank

religion as very important. Additionally, neither income nor education had much impact on parents' ranking (Hill, 1999). The work of Brody and Flor (1998) suggests that mothers who are more religious may interpret the behavior of their children in a more benign manner than do less religious mothers, resulting in higher tolerance levels and more supportive and involved parenting practices. These findings may reflect that spiritually grounded mothers may have more coping mechanisms to help deal with the stressors of parenting.

In a related vein, competence-promoting behaviors such as instrumental and emotional support, low levels of overt interparental conflict, harmonious family interactions, and higher quality mother–child interactions were more likely to emerge when African-American parents reported higher levels of religiosity and optimism (Brody & Flor, 1998; Brody et al., 1994a, 1995, 1996). In a study by Runyan et al. (1998), the most prevalent indicator of social capital for higher functioning at-risk families was neighborhood support. However, church attendance was found to be an important resource for 37% of the sample.

Although religion is of great importance for many families, very little research has been conducted that explores the relation between religion and the approach of religious families toward child maltreatment (Shor, 1998). In clinical assessments, religion has commonly been perceived as a protective factor that bolsters family functioning. Alternatively, Browne (1988) presents a model that suggests that religion can predispose one to commit child maltreatment. Nonetheless, it is important to recognize and communicate with African-American families about situations of child maltreatment through their norms, values, and child-rearing beliefs. For example, in working with parents on appropriate child-rearing practices, it would be significant to explore and develop an understanding of the religious rationale that parents give for their practices.

Because situations of child maltreatment are socioculturally bounded, professionals need not accept the family's definition as to what is or is not considered child maltreatment, but they do have to recognize the significance of the religious rationale in communicating effectively with these families (Cummings, 2000; Ellison & Sherkat, 1993). It might also be noted that many African-American families may feel more comfortable involving others who are active in their community, such as ministers or imams, to assist in situations of child maltreatment. For example, when faced with rise in the number of maltreatment reports from the Muslim community, the Cook County, IL, Department of Social Services enlisted the assistance of local religious leaders from the Nation of Islam, and hired women from that community to work with the identified families (ACF, 2003b). The above findings and practices suggest that sociocultural factors are of key importance when examining minority family processes and developing potential interventions.

## Promising Programs and Practices for African-American Families

Given the culture-specific recommendations from the literature, it is important to note how program developers and African-American communities are responding to the call for more culture-specific services for this group of families. In communities across America, African-American parenting programs are emerging that give voice to the unique experiences of this minority group. Although general parenting programs are not specifically geared to prevent child maltreatment, many universal and culture-specific program elements may improve parent–child interaction and subsequent child well-being.

Several parenting programs address many of the aforementioned components relevant to African-American families. Some programs are larger in scale and have emerging empirical findings. Others serve the needs of smaller communities, yet they too provide vision for future programs and research. The following section highlights some of these promising programs. It is hoped that they serve as potential building blocks for child welfare organizations looking to incorporate and honor African-American values and traditions in their services.

The most comprehensive parenting program identified in the literature is the Center for the Improvement of Child Caring's *Effective Black Parenting Program* (EBPP) (Alvy, 1994). EBPP's basic ideas are grounded in writings from African-American scholars. Parenting skills and strategies are taught by incorporating African proverbs and other culture-specific narratives and artifacts. This program emphasizes helping African-American parents enhance the quality of their relationships with their children and to employ parenting strategies and skills that research has shown to be most helpful in raising prosocial, competent, and healthy children. EBPP has been nationally disseminated since 1988 and has been used with parents of children between 0 and 18 years. For parents of young children, the program addresses child abuse, learning disorders, behavior problems, and emotional disturbances. EBPP has been field-tested with promising results documented (Alvy, 1994; Myers et al., 1992).

As previously noted, many African Americans look to their religion to find support in their parenting. The *Black Family Ministries Parenting Program* (BFM, 2005) is an additional resource for Christian African-American families. This parenting program builds upon the well-established EBPP model to pioneer a faith-based adaptation from a Christian perspective (BFM, 2005). This initiative is currently being implemented in church communities across by the National Council of Churches of Christ (NCCC) and underscores the intersection of culture, religion, and parenting for many African-American families seeking services.

Another promising culture-specific parenting program is the *Enhancing Nurturing Parenting Skills for African-American Families Program* (Bass &

Moody, 2003). The program is a supplement to the *Nurturing Parenting Program®* (Bavolek, 2003), but can also be used as a separate curriculum. This cultural adaptation of the original program incorporates diversity issues, black history, how to transcend oppression, dual consciousness, spirituality, and teaching black children how to access resources. The original *Nurturing Parenting Program®* has been field-tested and has been validated with diverse samples (Bavolek, 2003). However, evaluation data are needed for the version of the curriculum designed to be used with African-American parents.

In addition to the widely distributed and implemented curricula mentioned above, there are dozens of other culture-specific programs serving smaller communities across the country. Such programs incorporate African and African-American history, cultural processes, and rituals into parenting classes and other program activities. Child welfare organizations truly interested in collaborating with ethnic minority communities should examine what culturally relevant programs already exist, and find ways to partner and consult with these indigenous institutions and programs.

## Implications for Practice

Interventions designed to support young children and families have been found to be effective in preventing a variety of negative child, parent, and family outcomes, notably child maltreatment and its sequelae (Guterman, 1997; Olds et al., 2000). The effectiveness of these programs is contingent on many factors, which have been described by various prevention scholars. Following is a delineation of core features of prevention programs that are generalizable to maltreatment prevention programs (Nation et al., 2003; Olds et al., 2000).

- Have strong theoretical and empirical foundations (e.g., developmental epidemiology, ecological and cognitive-behavioral approaches).
- Are comprehensive in nature and address multiple individual and ecological risk and protective processes (e.g., parental history of maltreatment, current relationships).
- Provide a sufficient dosage of the program (i.e., frequent contact and long durations).
- Are staffed by well-trained and supervised interventionists (some evidence that these should be professional staff persons).
- Provide developmentally appropriate services that capitalize on the optimal timing of the intervention (i.e., during pregnancy, the transition to parenting, or the child's first year of life).
- Are culturally appropriate and build on the strengths of a community (e.g., cultural mandate to protect children, achievement motivation).

**Table 2.1. Cultural Process and Programs for African-American Families**

| Cultural tradition | Program feature | Program exemplar |
|---|---|---|
| Extended family | Capitalize on relative, fictive kin, and other informal community supports | Family Group Conferencing |
| Fathers as a caregiving support | Incorporate father involvement and support services | Head Start Father Involvement Initiative |
| Religiosity | Use religious leaders/affiliates for public awareness and services to families | Cook County Nation of Islam Partnership |
| Intergenerational transmission of cultural mandates | Use community elders to transmit cultural mandates around protecting children | Foster Grandparent Program; Elder Mentor Program |
| Communalism | Collaborate with families and communities by using community persons to design interventions and provide services to families | Strong African-American Families Program; Elder Mentor Program |

In line with these principles, Guterman (1997) has suggested that programs be offered universally to a demographic risk group (e.g., minority adolescent mothers), rather than be targeted to families at high risk for maltreatment per se. He also recommended that components of maltreatment preventive interventions for young children and families include (1) education and support to assist parents to provide optimal care for young children, (2) linking families to informal and formal supports, and (3) health education that can address issues of medical maltreatment. Other essential features of child maltreatment prevention programs are (1) ensuring that the specific needs of families are met by appropriate ancillary interventions (e.g., substance abuse and mental health treatment); (2) providing services that promote family well-being as well as the development of the child; and (3) addressing the parent–child relationship through interactional activities, support, and therapy (Jones Harden & Lythcott, 2005).

Beyond these principles that may improve the effectiveness of any maltreatment program, the literature summarized in this chapter suggests certain culture-specific features that may enhance the effectiveness of these programs with African-American families. These features stem from an understanding of African-American cultural processes that have adaptive value for contemporary African-American families. Table 2.1 delineates specific cultural processes and how they may be manifest in maltreatment prevention components and programs.

Despite the limited evidence regarding the effectiveness of culture-specific interventions, the success of programs like *Strong African-American Families* (Brody et al., 2004) bodes well for the development of similar programs for young children and their families. Further, although the

early intervention programs described in this chapter have not been designed specifically to incorporate African-American cultural tenets, many of the programs have been tested with largely African-American samples. Interventions could be developed that are informed by this evidence base and that capitalize on culture-specific processes that characterize the African-American community. For example, extended family members and community elders could be used to augment the therapeutic services offered in homes and clinics and to staff center-based interventions designed to promote young child well-being. Additionally, African-American socialization and child-rearing values and processes could be integrated into parent education and support programs.

## Conclusion

Young African-American children have the unfortunate distinction of being most likely of all child groups to be victimized by abuse and neglect. Further, young African-American children are disproportionately represented in the foster care system. Unfortunately, there is a paucity of evidence-based interventions targeted at this population of children and their families. Given the evidence that African-American children and families receive fewer child welfare services than their Caucasian counterparts, it is important to establish and advocate for programs that should be implemented with this population. This chapter makes a step toward that end by delineating strategies to prevent maltreatment of young African-American children.

In order to stem the tide of young African-American children who are being doubly victimized by maltreatment and foster care placement, it is imperative that the child welfare field aim its resources and energies at this population. Further, the African-American community must take seriously its role to protect and nurture this very vulnerable group of young children. Designing interventions that draw the best from both the child welfare and the African-American cultural communities can do much to prevent the adverse experience with which young African-American children must contend, and to promote their development and well-being. The plight of this group of children will only be eased through the mutual embrace of both the child welfare and African-American cultural communities.

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# Chapter 3

# Interventions for Abused African-American Women and Their Children

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Intimate partner violence (IPV) affects millions of women regardless of age, race, and income in the United States; however, low income African-American women are disproportionately affected (Rennison & Planty, 2003). IPV is a major public health issue for African-American women because of the combination of institutional racism and the fact that IPV is more common and violent in this community (Hampton et al., 2003).

Annually from 3.3 to 10.0 million children are exposed to IPV (Carter et al., 1999; Fantuzzo et al., 1997). Children exposed to IPV manifest behavioral, emotional, cognitive, and family problems (Edleson, 1999a; Grych et al., 2000; Holden et al., 1998; Kolbo et al., 1996) and are at risk for child maltreatment (CM) (Holden et al., 1998). There is a dearth of empirical literature on interventions for abused women and their children (Peled, 1997b; Pepler et al., 2000), despite recent calls for evidence-based preventive interventions (Prinz & Feerick, 2003). Unfortunately, very little of the existing work has focused on African-American families. This chapter begins with a review of IPV and children exposed to IPV, with particular attention to the African-American community. Then evidence-based interventions for children exposed to IPV are reviewed, with a focus on what interventions work, what interventions might work, and what interventions do not work. The relevance of this work specifically to African Americans is highlighted. It is hoped that this section will provide a guide for working with families in which a child is exposed to IPV. Finally, there is a discussion of recommendations for future practice and clinically meaningful research in

the field of interventions for African-American women and their children exposed to IPV.

## Background

### *Interpersonal Violence (IPV)*

DEFINITIONS. IPV is a pattern of coercive behaviors including physical or sexual violence, threats of violence, and psychological/emotional abuse of one partner by a current or former partner (Salzman et al., 2002). There are four key patterns of IPV (Johnson & Ferraro, 2000). Common couple violence, the most frequently encountered form of IPV, is bidirectional, minor, infrequent, and not physically injurious. Intimate terrorism refers to exertion of control by one partner over the other, which is more frequent than common couple violence, likely to escalate over time, and may result in serious injury. Violent resistance is akin to self-defense. Mutual violent control refers to both partners striving for control through intimate terrorism.

DEMOGRAPHICS. Between 850,000 and 1.5 million women are raped and/or assaulted and over 1200 women are murdered by an intimate partner each year (Rennison, 2001; Rennison & Welchans, 2000; Tjaden & Thoennes, 2000b). There is a 22% lifetime prevalence of physical assault by a partner (Tjaden & Thoennes, 2000b). These figures likely underestimate the problem (Carden, 1994), but highlight that IPV is a serious public health concern and criminal justice problem.

One in three women who are physically assaulted or raped by an intimate partner are injured (Tjaden & Thoennes, 2000b). Annually, over 500,000 women in the United States seek medical attention following an IPV incident (Tjaden & Thoennes, 2000b). Women are particularly vulnerable to being abused during pregnancy; 324,000 women each year are raped and/or physically assaulted by their partner during their pregnancy (Gazmararian et al., 2000). As a consequence of severe IPV, abused women are more likely than their male counterparts to require medical attention, take time off from work, and spend more days in bed (Crowell & Burgess, 1996). Thus, battering is the most common cause of serious injury to women (Tjaden & Thoennes, 2000b) and is associated with health care costs in excess of 5.8 billion dollars annually. See online at (htpp://www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm).

The National Crime Victimization Survey (NCVS) revealed that 10.7 African-American women, 7.8 European-American women, and 4.5 women of other races (per 1000 persons) were IPV victims from 1993 to 1999 (Rennison & Planty, 2003). The National Violence Against Women Survey suggested that African-American women and men and

American-Indian-Alaska Native women and men were most likely to report IPV, whereas Asian Pacific Islander women and men tend to report lower rates of IPV than individuals from other minority backgrounds (Tjaden & Thoennes, 2000a). One study found that African-American women were the victims in more than half of the violent deaths occurring in the homes of female victims (Bailey et al., 1997). However, when income is considered, IPV rates are comparable between African Americans and European Americans (Rennison & Planty, 2003). Indeed, being poor is associated with experiencing IPV (Weinbaum et al., 2001). That said, there is some evidence that IPV takes more violent forms in the African-American than in the Caucasian community (Hampton et al., 2003) and shows a less consistent pattern longitudinally than is found in other ethnic groups (Jasinski, 2001).

It is a myth that same-sex domestic violence is not a widespread problem or that it occurs with lower frequency in comparison to opposite sex domestic violence (Burke & Follingstad, 1999). Rather, same sex domestic violence may be more prevalent than IPV in heterosexual couples (Turrell, 2000). Compared to their heterosexual counterparts, gay, lesbian, and bisexual individuals who are victims of IPV are less likely to report IPV, to seek assistance, or to receive as much help from the same resources (Potoczniak et al., 2003). Women living with female intimate partners experience less IPV than those living with male partners, suggesting that lesbian couples experience less IPV than heterosexual couples (Tjaden & Thoennes, 2000a). No data could be located on same-sex violence within the African-American community.

**Sequelae and Risk Factors.** Although only some IPV incidents are fatal, 99% of assaults result in medical sequelae and emotional distress (Campbell et al., 2002; J. C. Campbell et al., 2002; Campbell & Lewandowski, 1997; Coker et al., 2002). African-American women who are victimized report more physical symptoms than their nonabused counterparts (Porcerelli et al., 2003). In the African-American community, partner abuse may be frequent or severe in couples where the woman has a medical illness, such as HIV (Jones et al., 2003; Wyatt et al., 2000), and African-American women who attempt to negotiate with their partner to use condoms are more likely to be abused (Wingood & DiClemente, 1997). Similar to findings with Caucasian Americans, data with African Americans reveal that the psychological sequelae of IPV include: depression, anxiety, posttraumatic stress disorder (PTSD), dissociation, and suicidal behavior; low self-esteem, feelings of helplessness and hopelessness; cognitive distortions; and social isolation (Huang & Gunn, 2001; Kaslow et al., 2000; Kaslow et al., 1998; Kaslow et al., 2002; Manetta, 1999; Thompson et al., 2002; Thompson et al., 1999). Abused African-American women with high levels of negative and severe life events; a history of CM; and high levels of psychological distress, hopelessness, and substance abuse are at

increased risk for self-harm (Kaslow et al., 2002; M. P. Thompson et al., 2002; Thompson et al., 1999). Those with low levels of self-efficacy are at increased risk for attempting suicide because of low levels of social support and difficulties securing resources (Thompson et al., 2002).

There are a number of risk factors for experiencing IPV; only those significant in the African-American community will be cited. First, substance abuse is a significant risk factor. More than 25% of African-American men who abuse their partners have substance abuse problems; many have psychological problems that stem from the substance abuse (Coker et al., 2000; Dennis & Key, 1995). A partner's history of alcohol abuse also predicts continued abusive behaviors (Cattaneo & Goodman, 2003). African-American women who are abused by their partners are more likely to use alcohol themselves (Huang & Gunn, 2001). A second risk factor is experiences of violence in one's family origin. African-American women who witnessed IPV as a child or who experienced violence from caregivers as a child are at increased risk for being in an abusive intimate partnership during adulthood (Coker et al., 2000; Ernst et al., 1997; Huang & Gunn, 2001; Wyatt et al., 2000). African-American men who came from families with IPV are more likely to perpetrate IPV in their intimate relationships (Huang & Gunn, 2001). Third, African-American men who abuse their partners are more likely to report elevated levels of stress (Huang & Gunn, 2001). Fourth, relationship-variables associated with current and continued abusive behavior include separation or divorce, severity of abuse, level of psychological abuse, partner jealousy, lower partner empathy, and the victim's own assessment of the level of dangerousness posed by the relationship (Cattaneo & Goodman, 2003; Coker et al., 2000; Ernst et al., 1997; Raj et al., 1999). Fifth, low income, receiving government aid, partner unemployment or intermittent employment, and low levels of partner education are salient risk factors within the African-American community (Coker et al., 2000; Ernst et al., 1997; Honeycutt et al., 2001; Kyriacou et al., 1999; Raj et al., 1999; Wyatt et al., 2000). Sixth, a history of incarceration is associated with IPV in African Americans (Richie, 1996). Finally, neighborhood characteristics are risk factors for IPV within the African-American community, including poverty, a high rate of change of residence, and poor educational opportunities (Cunradi et al., 2000; Grisso et al., 1999).

**Protective Factors.** Unfortunately, few protective factors have been examined in the African-American community. However, a growing body of literature reveals that abused African-American women with high levels of social support have fewer negative outcomes (Bender et al., 2003; Coker, Smith et al., 2002; Coker et al., 2003; Huang & Gunn, 2001; Kaslow et al., 1998; Kaslow et al., 2002; Mitchell & Hodson, 1983; Thompson et al., 2000). These women are likely to seek support from their own family, the family of the perpetrator (Yoshioka et al., 2003), friends, clergy/spiritual leaders, a member of their community, or a physician (Fraser et al., 2002).

Abused African-American women who are hopeful, feel self-efficacious, cope well, and are effective at obtaining resources are somewhat buffered from the negative impact of abuse as evidenced by decreased suicidal behavior (Kaslow et al., 2002).

**IPV and Parenting.** In the African-American community, IPV is associated with the presence of children in the home (Raj et al., 1999). IPV creates stress in parenting and negatively impacts parenting (Holden et al., 1998; Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998, 2000a, 2000b, 2001; Levendosky et al., 2003; Levendosky et al., 2000; McCloskey et al., 1995; Wolfe et al., 1985). Abused women believe that their parenting is affected by the IPV (Levendosky et al., 2000) and feel less effective as parents (Graham-Bermann & Levendosky, 1998). They may display less warmth with their children (McCloskey et al., 1995) and IPV predicts maternal warmth beyond other systemic and individual factors (Levendosky & Graham-Bermann, 2000a). Compared to nonabused women, abused women are less consistent in their parenting, less likely to monitor their children, more physically aggressive, and use more corporal punishment (Chapple, 2003; Holden et al., 1998; Straus & Gelles, 1990). When IPV-survivors are focused on basic safety and survival, their capacity to attend to their children's emotional needs is compromised and they are distressed that they cannot protect their children from IPV exposure (Augustyn et al., 1995; Osofsky, 1995). Battered women may modify their parenting when their abusers are present to minimize violence (Holden et al., 1998). These parenting difficulties negatively impact children's adjustment (Levendosky & Graham-Bermann, 2001) and capacity for attachment (Zeanah et al., 1999). On the other hand, some data suggest positive parenting among many abused women (Holden et al., 1998; Holden & Ritchie, 1991; McCloskey et al., 1995) and for the subgroup of mothers who are not depressed or traumatized by the IPV, IPV may be associated with more positive parenting (Levendosky et al., 2003) and resource mobilization on behalf of their children (Levendosky et al., 2000). Women's concerns for their children often are associated with efforts to leave abusive partners (Hilton, 1992). Women with children in their home are more likely to seek counseling and support services than women without minors in the home (Henning & Klesges, 2002).

**Help-Seeking.** Many abused women do not seek mental health, social, or legal services (Henning & Klesges, 2002). Less than 10% seek refuge at shelters and less than 35% obtain counseling (Gondolf, 1998; Hutchison & Hirschel, 1998; West et al., 1998). African-American women are less likely to seek shelter services than women of other ethnic groups (Fraser et al., 2002; Joseph, 1997), and they are not likely to turn to shelters until the violence against them becomes quite severe (Coley & Beckett, 1988; Sullivan & Rumptz, 1994). This reluctance to go to a shelter may partly

reflect concerns about racism and feeling unprotected outside the African-American community (White, 1985). There is also evidence that African-American women are also less likely to call the police, utilize the courts, obtain restraining orders or seek counseling than their abused Caucasian counterparts (Joseph, 1997; Sorenson et al., 1996). They may be reluctant to leave an abusive relationship due to concerns that they will place their partner in grave danger of being brutalized by law enforcement personnel, as well as fears of being stereotyped as an African-American woman who complains a lot, is never satisfied, and does not support her partner (Saunders-Robinson, 1991). However, not all studies have found African-American women to be less likely to seek help than women from other ethnic groups (Gondolf et al., 1991). Indeed, some African-American women are more likely to communicate with their health care providers about their abusive situation (Rodriguez et al., 2001). Further, abused, African-American women striving to heal from IPV are interested in receiving emotional and psychological support through support groups comprised of other African-American women (Taylor, 2000). They benefit most from groups that take into account the stages of disengagement from an abusive relationship prominent for African-American women (Taylor, 2002a) and that underscore that African-American women who can extricate themselves from abusive relationships feel more content and free, and have higher self-esteem (Molina, 2000).

INTERVENTIONS. Despite the proliferation of work on IPV screening, no controlled study has ascertained if screening leads to improved outcomes (Wathen & MacMillan, 2003). Few controlled studies support the effectiveness of community-based interventions (Wathen & MacMillan, 2003) such as shelters, crisis hotlines, support groups, and legal aid (Goodman et al., 1993). Likewise, there is a paucity of empirical studies on the efficacy of individual or group interventions for abused women (Kanuha, 1994). The following are some notable exceptions. Tutty and coworkers (Tutty et al., 1993), in a noncase-controlled study, found that support group participation yielded improved self-esteem, perceived support, internal locus of control, perceived stress, and marital functioning at postintervention and followup. Women who remained with their partners reported reduced IPV at postintervention. Varvaro and Palmer (Varvaro & Palmer, 1993) found that a self-efficacy group program for abused women that included teaching and active learning led to increased self-efficacy.

In the most methodologically sound series of studies, Sullivan and colleagues (Sullivan et al., 1992) examined the impact of advocacy services for women leaving battered women's shelters using the Experimental Social Innovation and Dissemination (ESID) model. Women were randomly assigned to an experimental or control condition. Women in the intensive community-based experimental condition were assigned an advocate to help them obtain community resources that would maximize their ability

to reduce IPV. Women in the control condition did not receive intervention. At 10-week follow-up, women who received advocacy services reported greater effectiveness in obtaining community and social resources, and greater improvements in quality of life and social support compared with women who did not receive these services. No between-group differences were noted in abuse outcomes. A 6-month follow-up (Sullivan & Rumptz, 1994) found that all gains were maintained except for those related to social support. A subsequent study with 278 women employed the same design (Sullivan & Bybee, 1999). Participants were interviewed upon leaving the shelter, 10 weeks later, and at six, 12, 18, and 24 months. Women who worked with an advocate experienced less violence over time, reported higher quality of life and social support, and had less difficulty obtaining community resources. More than twice as many women in the experimental condition experienced no further IPV across the 2 years postintervention compared with women in the control condition. Examination of the mediational processes at 24 months showed that the intervention was effective initially as it increased women's connections to needed resources, people, and opportunities. It continued to exert positive changes in women's lives by affording more opportunities for success and serving as protective factors against further abuse (Bybee & Sullivan, 2002).

There is also literature on couples interventions (Stith et al., 2002; Wathen & MacMillan, 2003), including some randomized controlled trials (Dunford, 2000; Stith et al., 2004), but this approach is controversial (Stith et al., 2003). Despite the controversy, there is initial evidence that thoughtfully conceived and implemented conjoint treatment is at least as effective as traditional interventions for IPV and does not place women at increased risk for violence (Stith et al., 2003). There is also data that couples treatment offered in a group format is more likely to be associated with increased relationship satisfaction and decreased relationship aggression than treatment of individual couples or no treatment at all (Stith et al., 2004). Recently, some case report data has suggested that couples therapy focused on the development of conflict management skills and strengthening support networks to decrease social isolation can be effective in preventing violence in low income, African-American couples (Jackson-Gilfort et al., 2000).

There is a burgeoning literature on intervention programs for male batterers. Unfortunately, with a few exceptions (Babcock & La Taillade, 2000), these programs have not been subjected to scientific scrutiny. The most well-known batterer interventions are based either on a feminist psychoeducational approach (e.g., Duluth Model) (Pence & Paymar, 1993) or a cognitive-behavioral framework (Sonkin et al., 1985). Typically, these interventions are administered in a short-term, small group format, and focus on anger management, skill building, and resocialization. To date, the data suggest that most men who complete these programs cease to be abusive for at least some period of time following program completion (Gondolf, 2000; Tolman & Edleson, 1995) and there appear to be successful outcomes

in 50–80% of the cases (Stith et al., 2002). These findings must be considered with caution given that only about one-third of offenders actually complete the programs (Babcock & La Taillade, 2000). Although no efficacy studies have been conducted specifically with African-American male batterers, there is some indication that when administered through the criminal justice system, batterer interventions may be promising for addressing IPV in the African-American community (Dennis & Key, 1995). In addition, although there is some information about parenting groups for men who batter (Matthews et al., 1990), the effectiveness of these programs has not been studied systematically.

## Children Exposed to IPV

### *Definition, Demographics, Sequelae, Mediators, and Moderators*

There are no clear agreed-upon definitions of child exposure to IPV and differences of opinion about whether it should be called child witnessing or exposure to IPV. Child exposure is a more inclusive term that refers to different types of experiences and does not assume that the child actually witnesses the violence (Holden, 2003). Children may be exposed prenatally, intervene to stop the violence, victimized themselves, be an unwilling participant, be an eyewitness or overhear the violence, observe the initial effects of the IPV or experience the aftermath of the violence, hear about it after it is over, or be ostensibly unaware (Holden, 2003). In a sample of abused women with children, of whom 33% were African-American, 52% reported that the child yelled from across the room during the abuse, 21% reported that the child called someone else for help, while 23% became physically involved at least occasionally during an abusive incident (Edleson et al., 2003). There are a number of ways in which young people exposed to IPV in their family or home can be considered psychologically maltreated. Psychological maltreatment may take the following forms: being terrorized, corrupted, spurned, denied emotional responsiveness, isolated, and neglected with regard to their mental or medical health or educational needs (Holden, 2003).

In the United States, from 3.3 to 10.0 million children are estimated to be exposed to IPV annually (Carter et al., 1999) and at least one-third of US children witness IPV (Straus, 1992). Up to 25% of domestic homicides are witnessed by the children (Doyne et al., 1999). Children who are young, poor, living in female-headed households or homes with low educational level of the primary care provider are at particularly high risk for being exposed to IPV (Fantuzzo et al., 1997). Key characteristics of IPV related to children are: type of violence, nature of specific acts, presence of injuries, timing, escalation, type of perpetrator, perpetrator's relationship to child, victim's role in the assault, and resolution of the incident (Holden, 2003).

Exposure to IPV and the surrounding stress (e.g., marital conflict, family dysfunction, maternal depression resulting in reduced social support and nurturance, economic and social disadvantage, separation from parent, frequent moves, involvement of others in the family's life) affects children's adjustment (Campbell & Lewandowski, 1997; Peled, 1997a). Exposed children experience other adverse events: household substance abuse, mental illness in family members, parental separation/divorce, and incarceration of a family member (Dube et al., 2002). Children exposed to IPV are from two to four times more likely than children from nonviolent homes to exhibit anxiety, PTSD, depression, aggression, hostility, conduct problems, social withdrawal, low self-esteem, and risk-taking and escape behavior (Cummings et al., 1994; Graham-Bermann, 1996, 1998; Manetta & Pendergast, 2002; Margolin & Gordis, 2000; McDonald & Jouriles, 1991; Mertin & Mohr, 2002; Rossman et al., 1997; Rossman & Ho, 2000; Ware et al., 2001). Two recent meta-analytic reviews revealed significant overall effect sizes for exposure to IPV on children's emotional and behavioral problems (Kitzmann et al., 2003; Wolfe et al., 2003). IPV accounts for variation in children's externalizing and internalizing problems over and above other factors including genetics (Jaffee et al., 2002) and prior levels of psychological symptoms (Litrownik et al., 2003). There may be five patterns of adjustment among children exposed to IPV: multiproblem-externalizing, multiproblem-internalizing, externalizing, mild distress, and no problems reported (Grych et al., 2000).

The finding of increased rates of internalizing and externalizing behavior problems in children exposed to IPV has been replicated with low income African-American children (Kaslow et al., 2004; Manetta & Pendergast, 2002; McFarlane et al., 2003; Morrel et al., 2003). Low income, African-American mothers who have been victimized exhibit more depressive symptoms and engage in harsher parenting practices than nonabused women, which may account for the elevated rates of internalizing and externalizing symptoms in their children (Morrel et al., 2003).

Children exposed to IPV also may exhibit cognitive, physical, and social problems (Holden et al., 1998; Kolbo et al., 1996). Compared to a national sample, children exposed to IPV have lower verbal and quantitative skills, delayed cognitive development, poorer academic functioning, and more deficits in social cognition (Margolin & Gordis, 2000). They are at increased risk for medical hospitalizations, somatization, and school absences secondary to health problems. They have difficulties with social functioning (Marks et al., 2001), including problems with attachment, separation difficulties, and abandonment fears, feelings of loneliness, and peer conflicts (Chapple, 2003; Devoe & Smith, 2002; McCloskey & Stuewig, 2001). Exposure to IPV during childhood also increases beliefs about the acceptability of violence (Graham-Bermann & Brescoll, 2000), which may partially account for increased likelihood of experiencing or perpetrating IPV during adolescence and adulthood (Dutton, 2000; Ehrensaft et al., 2003;

Kwong et al., 2003; Stith et al., 2000; Whitfield et al., 2003). Further, exposure to IPV is a risk factor for long-term physical and mental health problems, including depression, trauma-related symptoms, and low self-esteem (Felitti et al., 1998; Silvern et al., 1995). Unfortunately, no studies have examined the longitudinal course of African-American children exposed to IPV.

Attention has been paid to mediators and moderators of the link between exposure to IPV and child adjustment (Margolin & Gordis, 2000). Child characteristics that mediate or moderate the link include age and gender, residence, social information processing, attributions, coping styles, locus of control, emotion regulation, cognitive ability and flexibility, temperament, and CM status (Grych et al., 2000; Martin, 2002; Nicolotti et al., 2003; O'Brien et al., 1995; Wolak & Finkelhor, 1998). IPV factors include: relationship to the perpetrator, time since IPV exposure, proximity to violent threat, unexpectedness and duration of the experience (s), extent of violent force and the use of a weapon, number and nature of threats, witnessing of atrocities, relationship to the assailant and other victims, use of physical coercion, degree of brutality and malevolence, mother's response to the violence, and children's appraisals of the conflict (Grych et al., 2000; Pynoos, 1993; Sullivan et al., 2000). Family and social mediators and moderators include perceptions of relationships to adults in the home; family attachment patterns; maternal psychological functioning, stress, authority-control, and history of CM; paternal irritability; parenting styles and disciplinary practices (warmth, acceptance, inconsistent discipline, hostile control); parental stress; marital satisfaction; perceived family and extrafamilial support; and whether or not the child has been maltreated (Gonzales et al., 1996; Harper et al., 2003; Holden et al., 1998; Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998, 2000a, 2000b, 2001; Levendosky et al., 2002; McIntosh, 2002; Morrel et al., 2003). Not all studies find family variables to mediate the association between IPV and child outcomes (McCloskey et al., 1995).

### *Child Exposure and Child Maltreatment (CM)*

One of the most serious sequelae of IPV is CM (Edleson, 1999b) and a developmentally informed ecological model is useful in understanding this link (Little & Kantor, 2002). Children exposed to IPV are at high risk for abuse and neglect (Dube et al., 2002; Hartley, 2002; Holden et al., 1998), particularly when there are high levels of economic and parenting stress (Margolin & Gordis, 2003). They often are the victims of CM by their mothers or the perpetrators of IPV. Cooccurrence of IPV and CM in a community sample is 6% (Appel & Holden, 1998). In clinical samples of women with IPV histories or maltreated children, the overlap ranges from 20–100% (Appel & Holden, 1998). When a conservative definition of CM is used, a medium cooccurrence rate of 40% is found (Appel & Holden, 1998). Between 40–70% of children entering shelters are maltreated (Campbell & Lewandowski,

1997). Few studies of the cooccurrence of IPV and CM specify the racial or ethnic makeup of their sample, or include diverse populations (Edleson, 1999b). Double traumatization (i.e., being exposed to IPV and experiencing CM) is associated with problems in cognitive functioning (Margolin & Gordis, 2000), somatic complaints, emotional and behavioral problems, and social problems (Lystad et al., 1996; Maughan & Cicchetti, 2002).

A metaanalytic review indicated that cooccurrence of CM and IPV exposure increases children's emotional and behavioral symptoms beyond exposure alone (Wolfe et al., 2003). Children exposed to IPV and CM have problems with attachment, reduced social competence, and problematic peer relationships, and are more likely to be socially rejected (Margolin & Gordis, 2000). Some sex differences have also been noted (Lystad et al., 1996). Although some studies suggest that maltreated children exposed to IPV have more problems than those who have only witnessed IPV (Lystad et al., 1996; Sternberg et al., 1993), other studies do not find differences between children experiencing one versus two forms of family violence (Kitzmann et al., 2003; Mahoney, et al., 2003). Further, compared to nonmaltreated youth who have been exposed to IPV, exposed children who are also maltreated are more likely to live in families where there is a greater frequency and severity of IPV, lower levels of marital satisfaction, and a poorer father-child relationship (O'Keefe, 1995). These children are more likely to be aggressive (O'Keefe, 1995).

Evidence is less conclusive about factors that mediate the IPV exposure-CM link. Young maternal age, low education, low income, and lack of involvement in a religious community add to the risk for CM associated with IPV (Cox et al., 2003). Maternal psychopathology may mediate the IPV exposure-CM link (Wolfe et al., 1985). Both the amount of IPV witnessed and maternal-child aggression are related to child behavior problems, even when controlling for the child's age, ethnicity, and father status (O'Keefe, 1994).

## Interventions: Children Exposed to IPV

There is a dearth of methodologically sound research on interventions for children exposed to IPV (Graham-Bermann, 2001), and none of these studies are designed to be culturally competent interventions specifically for African Americans. Community interventions include police intervention, shelters, child protective services, visitation centers, and early childhome visitation (Centers for Disease Control and Prevention, 2003; Peled, 1997b). Initially, interventions were symptom-focused, but recently have become based on theorized mechanisms of change (Graham-Bermann & Hughes, 2003). Although some protocols have appeared for brief interventions with children of battered women, few present empirical findings (Hughes, 1982; Tutty & Wagar, 1994). Limitations noted in early studies

include: small sample size, lack of manualized treatment protocols, poorly defined criteria for inclusion, no comparison groups, and no formal follow up (Graham-Bermann & Hughes, 2003). A few community-based intervention programs have appeared, but most did not use a control group (Grusznski et al., 1988; Jaffe et al., 1988). In the following section, we discuss treatments that work, treatments that might work, and treatments that do not work.

## *What Works*

According to the American Psychological Association's Task Force on the Promotion and Dissemination of Psychological Procedures criteria (Chambless et al., 1996; Chambless et al., 1998; Chambless & Hollon, 1998), for an intervention to be deemed well-established, there must be at least two good between-group design experiments demonstrating efficacy in one of the following ways: (a) superior to pill or psychological placebo or to another treatment; or (b) equivalent to an already established treatment in experiments with adequate sample sizes. The experiments must be conducted in accordance with a treatment manual, sample characteristics must be detailed, and at least two different investigators or investigatory teams must demonstrate intervention effects. For an intervention to be classified probably efficacious, either two experiments must demonstrate that the intervention is more effective than a wait-list condition, or one or more experiments must meet all criteria for a well-established treatment except for the requirement that treatment effects be shown by two different research teams. According to these definitions of what works, there currently are no interventions for children exposed to IPV that meet the criterion for well-established or probably efficacious, and thus it is premature to conclude that any intervention clearly is effective. Because the aforementioned criterion require only two methodologically sound studies to be deemed effective or probably efficacious, and no studies qualify, and because the criterion for this book are three solid investigations, then clearly none of the studies conducted to date meet the categorization of treatments that work for this review.

## *What Might Work*

Because none of the interventions examined to date meet the strict criterion for well-established or probably efficacious, we will rely upon the guidelines set forth by Nathan and Gorman (Nathan & Gorman, 2002) in *A Guide to treatments that work*, to consider in this section promising interventions, which can be classified as Type 1, Type 2, or Type 3 studies. Nathan and Gorman (Nathan & Gorman, 2002) delineate criteria for six types of studies ranging from the most methodologically rigorous clinical trials (Type 1 studies) to case studies, essays, and opinion

papers (Type 6 studies). Specifically, Type 1 studies refer to double-blind, randomized-controlled prospective clinical trials that have a clear delineation of sample characteristics, state-of-the-art assessment and diagnostic procedures, adequate sample size, comparison groups, and appropriate data analytic procedures. Type 2 studies are clinical trials that lack some components of a Type 1 study. Type 3 studies are those with pilot-data and case-control methodologies. Type 4 studies use sophisticated data analytic techniques (e.g., metaanalysis) to conduct secondary data analysis. Type 5 studies are reviews, without secondary data analysis, that overview the literature and give opinions. Type 6 studies are described above.

**Type 1 Studies.** There are three studies that can be classified as Type 1 studies, all of which are manual-based. The first is *Advocacy and the Learning Club.* Sullivan and colleagues (Sullivan et al., 2002) compared a community-based intervention versus a control condition for abused women and their 6-1/2–11-years of age children. Forty-four percent of the sample was African-American, and 55% of the children were female. The experimental intervention incorporated advocacy for the women, who received help with difficult issues regarding their children, as well as support in obtaining goods and services, legal issues, employment, education, social support, childcare, housing, and transportation (Advocacy). This intervention also included mentoring for the children and a 10-session education and support group for the older children (The Learning Club). These families received free services from a trained paraprofessional (undergraduate mentor) for 6–8 hours per week over 16 weeks. The protocol included measures of both the assailant's abuse of the mother and the assailant's abuse of the child. Some of these measures were developed for this particular study, whereas other measures are more standard tools used in clinical-research and include a shortened version of the Index of Psychological Abuse, a modified version of the Conflict Tactics Scale (Straus, 1979). In terms of the child's witnessing of abuse, mothers were asked one question about the child's witnessing of ridicule and control, and two questions about the child's witnessing of threats and physical abuse. At postintervention, compared to children in the control group, children in the experimental condition endorsed greater levels of self-competence, and their mothers reported greater reductions in depressive symptoms and more improvements in self-esteem. There is some suggestion that children in the experimental intervention had greater reductions in their exposure to family violence than did youth in the control group. Treatment gains were maintained at 8-month follow-up.

In response to a growing body of evidence that one-third or more of children who accompany their mothers to domestic violence shelters exhibit clinically significant levels of conduct disorder symptoms (Grych et al., 2000; Ware et al., 2001), Jouriles and coworkers (Jouriles et al., 2001) developed *Project SUPPORT* to address concerns about these children.

Project SUPPORT was designed for mothers and children in which the mothers had sought refuge at a woman's shelter due to IPV, at least one child in the family was manifesting elevated levels of conduct disorder symptoms, and following their departure from the shelter, the mother's goal was to establish a residence independent from the abuser. Jouriles and colleagues (Jouriles et al., 2001) randomly assigned 36 families of battered women departing from women's shelters and their 4–9-year-old-children with conduct-disordered symptoms to an experimental condition consisting of instrumental and emotional support and child management skills to mothers versus a comparison group receiving services as usual. Of the 36 families, 11 (31%) were African-American. The intervention, composed of two primary components (Ezell et al., 2000; Jouriles et al., 1998) included weekly sessions of 1–1/2 hours in duration, and the sessions were conducted in the family's home following their departure from the shelter for a period of no more than 8 months. Weekly attendance was not required, but rather the intervention was designed to be flexible in order to accommodate the needs of the family. The first component entailed providing mothers and children with social and instrumental support and mothers with problem-solving skills, similar to the advocacy intervention of Sullivan and colleagues, designed for women departing from battered women's shelters (Sullivan et al., 1992; Sullivan & Bybee, 1999; Sullivan et al., 1994; Sullivan & Davidson, 1991; Tan et al., 1995). This component also incorporated the decision-making and problem-solving skills. The second component involved teaching mothers to use certain child management and nurturing skills that have been shown to be effective in the treatment of clinically significant levels of conduct problems. The Conflict Tactics Scale–Physical Subscale was used to assess IPV in the mother. There was no measure of the child's exposure to IPV. Families were evaluated over 16 months following shelter departure (8 months after the completion of the intervention). The average number of sessions for families who completed the intervention was 23. Compared with children in the control condition, children in the experimental group improved more rapidly and displayed lower levels of conduct problems. Their mothers exhibited greater improvements in child management skills. Mothers' distress symptoms and children's internalizing symptoms decreased during the intervention and follow-up period, but rates and levels of improvement in these two areas of functioning were comparable between the two groups. Recently, these families were followed for 24 months following the termination of the intervention, and 32 months following shelter departure. At this latter juncture, only 15% of children in the Project SUPPORT group still exhibited clinically significant levels of conduct problems, whereas 53% of the control group children exhibited these difficulties. In addition, children in the experimental group were rated by their mothers as being happier and better adjusted socially than were the children in the control group. Further, mothers in Project SUPPORT used less aggressive management

techniques and were less likely to return to their abusive partners than were mothers in the control condition.

Graham-Bermann (Graham-Bermann & Brescoll, 2000) has been studying *The Kids Club* for over a decade. The Kids Club is built on the assumptions that young people learn maladaptive behavior patterns through observing violence in the family, and that many children exposed to IPV are traumatized by their experiences, which in turn leads to the development of problematic self- and other- schemas. The 10-week intervention, The Kids Club for the children, focuses on family violence education, reducing fears and worries, building social skills, and promoting positive beliefs about families and gender. The parallel parenting program is designed to empower abused women to discuss the impact of IPV on the child's development, to bolster parenting competence, to provide a safe place to discuss parenting concerns, and to enhance the mother's self-esteem. In a study to evaluate the efficacy of The Kids Club, 221 families with 5–13-year-olds who experienced IPV were assigned randomly to one of three conditions: a child-only intervention condition, child plus mother intervention condition, or a no intervention comparison condition (Graham-Bermann & Hughes, 2003). The sample included approximately 40% African-American families. Although all three groups demonstrated improvement in internalizing problems over time, change was greatest in the child plus mother groups and least in the comparison group (Graham-Bermann, 2000). Changes were noted for externalizing behaviors, for all three groups, with children in the child plus mother intervention demonstrating the greatest change. The researcher concluded that although the child-only intervention program is effective for reducing children's adjustment problems, it is more effective when empowerment and parenting support were also offered to the mother. There is no discussion of the measures of IPV or exposure to violence in the descriptions of this study, nor are follow-up data provided.

**Type 2 Studies.** Although the initial evaluation of the Child Witnesses of Wife Abuse Program is a Type 3 study, a later evaluation of this program is best classified as a Type 2 study, and thus this program is presented here. Using a quasiexperimental design (Type 3 study) to examine the Child Witnesses of Wife Abuse Program (Wilson et al., 1989), a psycho-educational program that imparts information about family violence and incorporates exercises designed to help a child enhance his/her social skills and build self-esteem, Jaffee and colleagues (Jaffe et al., 1988; Jaffe et al., 1986; Wilson et al., 1989) found that children participating in the program changed their attitudes about violence, developed strategies for self-protection, and viewed their parents more positively. Mothers noted that their children had better adjustment. However, there was no information about the ethnic composition of the sample or the measurement tools used, and there was no comparison group or follow-up evaluation. Wagar

and Rodway (Wagar & Rodway, 1995) compared the protocol of Jaffee and colleagues (Jaffe et al., 1988) versus a control group with 42 (8–13-years of age) children of battered women (Type 2 design), but again no information on the ethnic composition of their sample. They used the Conflict Tactics Scale to assess IPV for both pre- and posttreatment evaluations. In addition, the Child Witness to Violence Questionnaire was used to measure attitudes and responses to anger, knowledge of support and safety skills, and sense of responsibility for the parents and the violence. Parent and child interviews also were conducted. At postintervention, compared to the control group, children in the treatment group showed greater improvements in sense of responsibility for the parents and the violence and attitudes and responses to anger. No significant between-group differences emerged with regard to improved knowledge of safety, nor for enhanced coping through the use of social support. Although these preliminary findings suggest that the Child Witnesses of Wife Abuse Program can change children's attitudes about family violence, they must be viewed with caution given the small sample size, unequal group size, lack of rater blind to condition, and lack of systematic (formal) follow-up assessments. However, the availability of a training manual is a definite strength of these studies.

**Type 3 Studies.** Type 3 studies, although less rigorous, may provide insights into interventions that are worthy of more sophisticated study. The first group of Type 3 studies focuses on a 10-week *group program* for 4–12-year-old children who witnessed family violence conducted by Peled and Davis (Peled & Davis, 1995). The program, conducted in accord with a treatment manual, was designed to foster a safe and positive setting to facilitate children's capacity to break the secret of violence in the family, teach self-protection strategies, enhance self-esteem, and alter attitudes about family violence. There was an optional final family meeting open to all family members, as well as a voluntary supportive, psychoeducational parenting group. Using qualitative methodology, Peled and colleagues (Peled & Davis, 1995; Peled & Edelson, 1992) evaluated their program for 30 children treated in eight groups. The group leaders conducted the qualitative interviews after the final session with children, their mothers ($n = 16$), their fathers ($n = 5$), and group leaders ($n = 9$) and triangulated data. Data also included observations of one complete group process (10 groups and three family sessions). The qualitative analysis revealed that all children discussed the family violence in the group, they increased their knowledge about IPV, changed their attitudes, and were more able to share their feelings about violent incidents. However, these findings need to be considered with caution because there were neither control groups nor follow-up evaluations, nor were there standard psychometric measures. There was no discussion regarding the race of the participants.

The next group of Type 3 studies focuses on *play therapy* and all of the studies are interrelated in terms of their sample. Kot and coworkers (Kot et al., 1998) compared intensive individual play therapy versus a wait-list control group (the latter being 70% African-American) for 22 children ages 4–10-year-old exposed to IPV who were residing in a shelter. The intervention was 45-minutes individual play therapy daily for 2 weeks. The children who received intensive individual play therapy showed greater increases in self-concept, more reductions in externalizing behavior problems, more improvements in overall behavior, and more adaptive play behaviors as compared to children in the control group (Kot et al., 1998). There was no information on the measures used to assess IPV or IPV witnessing. There was no treatment manual or follow up evaluation. Tyndall-Lind and colleagues (Tyndall-Lind et al., 2001) compared intensive sibling group play therapy with 10 children (i.e., 2 siblings in each play therapy group) versus a control group (i.e., Kot's wait-listed children) for 4–9-year-olds residing in a shelter. The sample consisted of 20% African-American children in the experimental condition and 27% in the control group. There was no discussion of measures of IPV or children's exposure to IPV. They found that sibling group play therapy offered in a shelter was associated with more improvements in self-esteem and greater reductions in emotional and behavioral problems (e.g., total behavior problems, externalizing behavior problems, aggression, anxiety/depression) than that found for control group participants. Building on this work-play therapy work, Smith and Landreth (Smith & Landreth, 2003) compared a 12-session filial therapy parent training group (45% African-American), conducted within 2–3 weeks to individual play therapy, sibling play therapy, and no treatment comparison group. The children for some of the cells were those included in the above-described two studies. With a small sample, and unequal proportions of African-American children in each condition ranging from 20–70%, children in the filial therapy condition exhibited greater improvements in emotional and behavioral problems and self-esteem than those in the no treatment group. Few differences were noted across the three active conditions. Mothers in the filial therapy group exhibited improved ability to be empathic, communicate acceptance, and allow their children to be self-directive. Again, there was no information on measures of IPV or IPV exposure reported, no follow-up data, and no treatment manual.

The following Type 3 studies have fewer elements of a well-designed clinical trial than the aforementioned investigations. In the first treatment study conducted for 12 children, ages 3.5–11.5 (no ethnic data were reported) of battered women living a shelter (Hughes, 1988; Hughes & Barad, 1982), the *psychoeducational intervention* was aimed at enhancing parenting skills, as well as bolstering the children's self-esteem, ameliorating their anxiety symptoms, improving their coping skills, and modifying their beliefs about family violence. Findings from a self-report measure of anxiety

administered to the children, as well as measures of behavior problems completed by the staff and the mothers, revealed that the school-aged children had reductions in their levels of anxiety. However, no improvements in self-esteem or behavioral problems were found. Further, mothers rated their children's behavior more negatively than did staff members. Given the small sample size, lack of control group and follow-up data, and lack of a treatment manual, the results should be viewed with caution and their generalizability is questionable.

Pepler, Catallo, and Moore (Pepler et al., 2000) assessed 46 (6–13 year-old) children who attended a 10-week, nonmanulized, *Peer Group Counseling Program* that included peer group counseling and a concurrent mothers' support group. There was no control group or information on the ethnic composition of the sample. This study used a pre-postfollow-up design, with four assessment time-points. Using standard psychometric measures, results revealed a significant improvement in children's self-reports of depressive and anxious symptoms and mothers reports of children's emotional and hyperactive behavioral problems. There was no relation between mothers' involvement in the intervention and children's improvement.

Grusznski and coworkers (Grusznski et al., 1988) offered a nonmanual-based *support and education,* unstructured, 10-session group conducted separately for young children and adolescents. Their sample of 371 youth (ethnicity not reported) for whom there were clinical rating scales completed by the group leaders ranged in age from under age four through older adolescence. A review of the clinical rating scales, which used global criteria, indicated that by the end of the program, the majority of the children acknowledged that violence was an issue in their family and that they were not to blame for the violence. In addition, the leaders indicated that the youth had enhanced self-esteem, had learned new methods for self-protection and nonviolent means for solving problems, and had increased their awareness of formal and informal resources available for them in safety planning. It should be noted that there was no control group and no collection of outcome data from the youth or their caregivers.

Finally, the *Storybook Club*, a 10-session, weekly program conducted at a YMCA in a Canadian City, was designed for 5–7-year-olds; the sample size and demographics were not presented (Tutty & Wagar, 1994). The aims of the program were to teach these young children, in a developmentally appropriate fashion, problem-solving practices, conflict resolution skills, and safety planning. Fairy tales were used as a metaphor for self-expression. Six groups of children and their mothers were assessed in their homes before and after the completion of the 10 groups. Although parenting stress, children's anxiety, and self-esteem were measured, no formal report of findings from these measures could be located. However, from the perspective of the group leaders, some children became more vocal and

others were more able to respond to limits in a group. Anecdotal feedback from both parents and teachers suggested that the children benefited from the program.

### *What Does Not Work*

There is no empirical literature that provides information about treatments that do not work for children exposed to IPV. This largely reflects the relatively sparse body of well-designed treatment outcome studies in this area, as well as the convention not to publish nonsignificant findings. Clinical lore, however, suggests that treatments that include the perpetrator of the IPV before that person has participated in his or her own intervention program and taken responsibility for the violence are unlikely to be successful. Clinical wisdom also suggests that interventions are not likely to be effective if the child not only is exposed to IPV, but also to CM, and if the perpetrator of the CM is participating in the treatment without his or her own prior intervention. Further, if the family members who participate in an intervention program are not committed to a violence-free family life, then psychosocial treatments will fail.

## Recommendations

There are three very promising interventions for children exposed to IPV: 1) Advocacy and the Learning Club, 2) Project SUPPORT, and 3) the Kids Club. Although these studies did not meet criterion for empirically supported or probably efficacious interventions, they are Type 1 treatments and thus are very promising. The studies conducted examining each of these intervention programs has utilized appropriate comparison groups, random assignment to condition, treatment manuals, assessment of treatment fidelity, multimethod and multiinformant assessments, and were adequately powered to detect between-group differences (Graham-Bermann & Hughes, 2003). In addition, these programs are based in theory and suggest that interventions that target both children who are exposed to IPV and their nonoffending parents are potentially effective. Subjecting these protocols to more in-depth scientific scrutiny is warranted. In the meantime, however, it is reasonable to incorporate these programs into shelters and other facilities that serve abused women and their children. In addition, some of the Type 2 and Type 3 studies appear to have considerable potential, but these too require more methodologically sophisticated examination before it can be concluded that these programs are treatments that work. It should be noted that while a number of the treatment outcome studies included a significant percentage of African-American children and their families, none of the programs were designed specifically for African-American children exposed to IPV.

The following are recommendations for future efficacy and effectiveness studies for abused African-American women and their children.

### *Make the Interventions Culturally Competent*

First, because responses to IPV are influenced by cultural norms (Raj et al., 1999) and African Americans are less likely to seek assistance from institutions that historically have contributed to their oppression (Wyatt, 1994), culturally competent interventions need to be developed, implemented, evaluated, and disseminated for abused African-American women (Bell & Mattis, 2000) and their children who have been exposed to IPV. These interventions need to be different for African-American women and children from different social-class backgrounds, due to the marked variations in presentation, needs, strengths, and responses for low, middle, and upper income families. Modifications also may need to be made based on region of the country, and whether or not the families are residing in urban, suburban, or rural areas. These interventions are likely to be most effective if the women and children are engaged in their development. This collaborative process is also likely to be empowering and healing (Taylor, 2002b).

Conducting comprehensive, culturally competent, coordinated, and family driven research is consistent with the Surgeon General's recommendations for children's services (US Public Health Service, 2000) and the New Freedom Commission Report (New Freedom Commission on Mental Health, 2003).

We are currently in the process of implementing a culturally competent program for abused low-income, African-American women and their children, entitled the *SAFETY Project, Supporting African-American Families Empowering their Youth*. This strength-based program builds upon key principles of Kwanzaa and is designed to enhance resilience and be empowering, culturally competent intervention strategies for this population (Jackson & Greene, 2000; West, 2002). This manualized intervention program offers both developmentally informed parallel groups for children exposed to IPV and abused mothers, as well as family interventions. When the parallel groups are provided, childcare is available for children too young to participate in their own groups. Given the centrality of the extended kinship network within the African-American community, these family meetings may include all people who are important in the lives of the children, such as grandparents, aunts and uncles, cousins, and "play family" members. Children of all ages are included in these meetings. Perpetrators are only included once they have engaged actively in their own treatment and the family is interested in reconciliation and reunification and a violence-free family life. The intervention is administered by at least one African-American therapist. The therapists are trained in the use of culturally meaningful communication strategies (Bell & Mattis, 2000). The

manual uses examples, handouts, etc. specific for African Americans. The targets of the interventions are also culturally relevant. For example, attention is paid to bolstering the extended family network, and increasing spiritual well-being and religious involvement (Bell & Mattis, 2000; Boyd-Franklin, 2003). Strategies found to be associated with "effective Black parenting" also are taught. Awareness of normative family and childrearing patterns in the African-American community guides the intervention. These interventions address the pain and shame that abused women and their children experience because of their sense that they failed to meet cultural expectations (Richie, 1996). Assessment tools used to measure outcomes and predictors of outcomes have good psychometric properties for African Americans, such as the Index of Spouse Abuse (Campbell et al., 1994; Cook et al., 2003), the Parent-Child Conflict-Tactics Scale (Straus et al., 1998), and measures of spiritual well-being, religious involvement, racial identity, etc. Family violence, including IPV, exposure to IPV, and CM are monitored weekly. Given that our sample is poor, financial incentives are provided, transportation is paid for, food is available for each assessment and intervention session, developmentally appropriate toys are given to each child in each session, and gifts are presented to the women to enhance their self-esteem (e.g., cosmetics) and reduce their financial burden. Assistance is offered to help families obtain necessary resources. The SAFETY team partners with African-American churches, local domestic violence and homeless shelters, and other community groups that serve children. The SAFETY team also provides the intervention in local domestic violence shelters. Although not done in the SAFETY Project to date, another strategy for enhancing participation would be the conduct of family meetings in the homes as is often recommended for work with African-American families with children (Boyd-Franklin & Bry, 2000) and as is done in multisystemic therapy programs (Curtis et al., 2004; Henggeler et al., 1998).

In addition to integrating popular culture into standard psychosocial interventions to enhance their cultural relevance, popular culture interventions can be more community-focused and thus of more far-reaching public health significance. These interventions may include radio campaigns, gospel music, well-known icons, African-American celebrities, and popular songs (Oliver, 2000). Indeed, there is some evidence that a dramatic radio serial promoting IPV prevention in the African-American community is associated with more antidomestic violence beliefs and behaviors (Wray et al., 2004). Using music to aid in the healing process is consistent with what African-American women have historically done to soothe themselves, namely "singing the blues" (West, 2002).

Further, it behooves us to develop culturally relevant primary prevention programs. Such programs may be administered in schools, churches, or community centers located in African-American neighborhoods. These programs may be modifications of already available,

well-respected school-based programs such as "My Family and Me: Violence Free" (Stavrou-Peterson & Gamache, 1988) and "ASAP: A School-Based Anti-Violence Program (Sudermann et al., 1996).

Finally, as argued by Hampton and colleagues (Hampton et al., 2003), community-based efforts conducted within the context of the faith community, community centers, historically African-American social groups (e.g., sororities, fraternal orders), and the media must be utilized to reduce sexism and IPV within the African-American community. Social change efforts need to be put into place that target the risk factors for violence in this community, at least among lone African Americans, including joblessness, chronic underemployment, school drop-out, and teenage pregnancy (Hampton et al., 2003).

### *Make the Interventions Developmentally Informed*

When protocols are designed and implemented they need to be done so in a developmentally informed fashion. The intervention goals, therefore, must take into consideration findings regarding the ways in which children of different developmental stages are affected by IPV (Graham-Bermann, 2000). The interventions must focus on bolstering children's developmental capabilities and resilience. Developmentally informed interventions may include more play therapy oriented protocols for young children and more supportive and psychoeducational interventions for elementary school-aged children and adolescents. Because models that include ontogenic, microsystemic, and exosystemic factors best predict the effects of IPV on women and children (Levendosky & Graham-Bermann, 2001), an ecologically informed developmental psychopathology perspective is likely to be essential for interventions for be effective (Levendosky & Graham-Bermann, 2001; Margolin & Gordis, 2000; Mohr et al., 2000). The use of developmentally informed interventions for children exposed to IPV is in keeping with recommendations by the National Institute of Mental Health (Hoagwood & Olin, 2002; The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001).

### *Develop Sequenced Treatment Models*

Attention needs to be paid to examining sequential and concurrent treatments. For example, many clinicians advocate for separate groups for perpetrators, abused women, and children, followed by sibling meetings and/or sessions with the nonoffending and the children. For families invested in reconciliation or who remain together, the inclusion of couples' sessions and family meetings that include the perpetrator need to be evaluated in this sequence. It should be noted that if the family is invested in

staying together and if sequential treatment includes the perpetrator, it can only be effective if all parties are committed to a violence-free family life.

### *Develop a Stronger Evidence-Base*

Given the negative sequelae of exposure to IPV and the paucity of quality intervention outcome studies (Geffner et al., 2000; Graham-Bermann & Edleson, 2001), we need culturally and developmentally relevant intervention programs that are evaluated using methodologically sophisticated treatment outcome designs. These investigations must include a pre-postfollow-up design; appropriate comparison groups; random assignment to treatment to treatment condition; treatment manuals; assessment of outcomes by blinded raters; state-of-the-art assessment techniques; and presentation of effect sizes (Graham-Bermann, 2000). These interventions need to be evaluated by more than one investigative team. It would also be helpful if active interventions were compared to one another and if researchers ascertained which interventions were most beneficial to which children and families. These studies should also examine mediators and moderators of treatment outcome. In addition to the conduct of efficacy studies, effectiveness trials in myriad real-world settings that balance internal and external validity considerations also must be undertaken (Norquist et al., 1999; Seligman, 1995).

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Chapter 4

# Intimate Violence Between African-American Couples: Seeking Intimate Justice in the Midst of Social Injustice

Brian Jory

Violence between African-American couples exists at the point where racism, social class conflict, and gender discrimination converge (Bograd, 1999). For example, reliable estimates indicate that about 26% of women and 8% of men in the United States are likely to be physically assaulted, raped, or stalked by an intimate partner during their lifetime (Tjaden & Thoennes, 2000). Examined superficially, these data suggest that African-American males are, in general, about 1.5 times more likely than whites to use violence against their partners (p. 25). More sophisticated analyses, however, reveal that when household income levels are controlled, rates of intimate violence are the same between whites and African Americans at all income levels, with remarkably high rates of violence for couples of any race who live below the threshold of poverty (Rennison & Planty, 2003). African Americans are more likely to be registered among perpetrators and victims of intimate violence because black households are almost twice as likely as white households to be poor (US Bureau of the Census, 2002).

A recent 5-year study examined the volatile mix of low incomes, financial strain, male job instability, and living in disadvantaged neighborhoods and concluded that women in these circumstances are several times more likely than advantaged women to be severely and repeatedly victimized by a male intimate (Benson & Litton Fox, 2004). This same study found no differences in rates or severity of intimate violence between white and African-American women living in impoverished neighborhoods, but

did conclude that African-American women are, in general, more likely to be chronically and severely victimized because they are more likely to live in impoverished neighborhoods.

A number of authors have examined how historical and current racism in the United States impact African-American experiences with violence. For example, Wilson (1998) has argued that historical patterns of white oppression, which still have not been fully redressed, are involved in the etiology of male African-American violence. These patterns of oppression include slavery, lynching, rape, murder, economic and political disenfranchisement, segregation, job discrimination, substandard education, and others.

Hampton et al. (2003) described how racism in structural and cultural community contexts, exacerbated by the loss of manufacturing jobs in the United States during the last two decades, has disproportionately affected the ability of African-American males to provide for their families. They suggest that the resulting economic dependence of these under- and unemployed men on women may result in the adoption of alternative definitions of manhood among African Americans such as "the tough guy, the hustler, the player, the gangsta, etc." While these authors do not condone violence, they argue that the frustration of men who are chronically under-employed and unemployed must be considered in understanding African-American male violence toward women.

Williams (1999) observed that the oppression of African Americans has resulted in stressful and unsafe communities where black-on-black crime is not aggressively policed and prosecuted. In these communities, appearing to be weak can be dangerous, making violence and the show of violence essential for survival. In these neighborhoods, violence is routinely modeled for young African-American males as a way of resolving conflicts, achieving one's goals, and protecting one self. Although they are misguided, some of these men transfer the use of violence to the home place as a method of conflict resolution. Living in violent neighborhoods is stressful, and some black men may inappropriately displace the anger they feel about living in these stressful conditions to women and children, resulting in verbal aggression, psychological abuse, and violence in their home place (Johnson, 1998).

## Acknowledging Black Male Aggression

Many people within the African-American community acknowledge the problem of black male aggression. In the newly released film, *Diary of a Mad Black Woman*, dramatist Tyler Perry (2005) treats the audience to a comic inside view of marriage in an African-American working class family. Helen McCarter, a principal character in the film, wakes up on the dawn of her 20th wedding anniversary to find that her husband, Charles,

wants to divorce her for her best friend. For the audience, the laughs are good. Between the laughs, though, Perry has woven a morality play about the struggle between African-American couples in the 21st Century—a struggle partly focused on the betrayal of black women by black men. At the end, there is redemption for Helen and Charles, but not without some old-fashioned soul-searching about fidelity, fairness, and mutual respect.

Academic researcher Tricia Rose (2003) conducted ethnographic interviews with 20 African-American women, allowing them to testify about their life-long experiences with sexuality, emotional closeness, and intimacy. Although there is no claim that these women represent the entire African-American community, their testimonies express collective disappointment with how some African-American men treat women. Clearly, the women feel conflicted. On the one hand, they want to be loyal to their black brothers, fathers, sons, and lovers—men who have been victimized by the racism of America. On the other hand, the women also feel angry about their own victimization by some of these same men that they love. The reader of these testimonies gets a sense that, despite their ambivalence, these women are no longer willing to be silent victims of black male aggression simply for the sake of racial loyalty. For example, one woman described her anguish with black men like this: "Why should I love you? Men have hurt me as a black woman for so long, so why should I put down my anger? Why do I always have to sacrifice for you? So *you* can feel loved?" (p. 3).

Of course, intimate violence is not unique to African Americans; it is a serious problem in most communities and cultures. Moreover, the burden of solving intimate violence by black men should not be borne primarily by black women. Intimate violence is not a woman's problem or an African-American problem—it is a problem that belongs to all of us. In this statement, I am not advocating color-blindness or suggesting that all people are alike. Quite the opposite, I am saying that African-American male violence must be understood in light of the social injustices of racism and discrimination that exist in the institutions and social fabric of our society. There is concern about saying this, however, because a discussion about the social injustices experienced by African-American males might be misconstrued to excuse them from accountability for their violence. To do so, further victimizes black women and others. Recognizing this, nothing in this chapter should be construed to condone or justify intimate violence in any form.

This chapter examines ways to identify and assess physical and psychological abuse between African-American couples. Because effective assessment must be culturally competent, I try to focus on both the strengths and vulnerabilities of the African-American community regarding this problem. I will strike a balance between discussing assessment issues that apply to intimate violence in general, and those that fit the unique situations and needs of black men and women. After all, our lives are woven

out of multiple identities. In effect, sometimes a black woman sees herself primarily as an African-American; at other times she sees herself primarily as a woman. Similarly, it goes without saying that not all black men are alike and we need to be cautious about applying generalities to individuals. We all deserve to be understood as individuals. I am a white male who is committed to compassionately solving problems of violence in many forms. Ultimately, this chapter is intended as a small contribution to what is, hopefully, an ongoing discussion about solving intimate violence in all families, communities, and cultures. Therefore, this should not be considered the final word on any issue.

The chapter is written for mental health professionals who work in many types of settings: psychiatrists, psychologists, social workers, criminal justice personnel, and judges and prosecutors who want to understand intimate violence and how to better identify it. The chapter is divided into two sections. The first section addresses a major barrier in identification of intimate violence: secrecy. In this section, I discuss four instruments that conceptualize intimate violence in very different ways, emphasizing that violence is multifaceted and there are different ways to look at the problem. I make recommendations about the effectiveness of these instruments with African-American couples, and also address other issues of assessment. The second section presents an innovative approach for understanding and assessing intimate violence that I have developed, called intimate justice theory. The thrust of intimate justice theory is that both victims and perpetrators respond to assessment and interventions that are steeped in ethics and justice. Practically, victims of abuse and perpetrators of abuse are in very different places, psychologically speaking, and we need to tailor assessments to fit their very different needs. This section describes a written questionnaire to screen for victims of abuse, called the intimate justice scale, and also includes an informal approach for screening perpetrators, called the intimate justice question.

## Identifying Intimate Violence: Issues and Instruments

In 1976, the California Supreme Court heralded the so-called "duty to protect" by finding that mental health professionals have an obligation to take reasonable steps to protect potential victims from the violence of our patients (*Tarasoff v. Regents of the University of California*, 1976, p.131). Since 1976, at least 14 jurisdictions have adopted statutes requiring therapists to contact authorities if their patients might attack another person, and over 40 lawsuits have alleged that a mental health professional failed to take reasonable steps to protect an identified victim.

Most mental health professionals are aware of their duty to protect potential victims, but many overlook the fact that the Tarasoff case involved

intimate violence—a boyfriend who stalked and fatally attacked a former girlfriend. In fact, the most common scenario where a therapist might be held responsible to protect a potential victim involves intimate violence (Perlin, 1997). This involves couples where the therapist is aware of an ongoing pattern of violence, but can also be applied to couples where the therapist *should have known* about potential violence (Jory, 2001). This makes the routine assessment of intimate violence a legal necessity in all mental health agencies, but also a moral obligation because, unlike some other mental health problems, violence has the potential to cause severe and irreversible physical and psychological trauma, even death.

Effective assessment of violence is hampered by its secrecy, in particular, the reluctance of victims and perpetrators to reveal violence in the relationship. Even in a skillfully conducted clinical interview, therapists should not assume that victims will be forthcoming about abuse. Victims typically struggle with personal shame and fears of retaliation by the abuser. Psychological defenses, such as denial, minimization, and rationalization sometimes block victims' awareness that they are being abused, and ironically, these defenses are more likely to be exhibited by victims who suffer from the most severe violence (Campbell, 1995). These defenses help victims to maintain psychological equilibrium, but at the cost of realistically facing the danger they are in with a violent lover or husband.

For those who abuse their partners, secrecy functions within the couple and family system to keep the victim and others from intervening to stop it. The skill of abusers to deny their own violent actions, to minimize its destructive impact, and to rationalize their use of violence is frustrating to mental health professionals, to put it mildly. Not only do violent people lie about their violence, but they also usually threaten their victims into lying about it. The untouched victims who witness their violence, such as children and other family members, are also threatened into secrecy. Also, most violent individuals have multiple victims, either serially or simultaneously, who do not communicate with one another out of the fear of reprisal. Consequently, psychological and physical abuse remains in the silent confines of the family where victims stay quietly resigned, out of the sight of mental health professionals.

Secrecy about intimate violence may be even more pronounced among African-American clients, particularly when therapists are white and middle class (e.g., see Turner et al., 2004). Black clients are often distrustful of whites, based on historical and contemporary betrayal by whites who practice racism, degrade African-American ideas and culture, and relegate the needs of black people to the "do later" pile. The vast majority of white mental health professionals are motivated by good intentions, but they frequently lack knowledge about black families and their needs. For example, how many white mental health professionals live in racially segregated neighborhoods? How many attended racially segregated schools? This is not a condemnation of white professionals, but raises the issue

of how much they really know about African-American needs regarding violence and abuse.

Regarding secrecy, it is important to keep in mind that intimate violence is a crime in most jurisdictions. Black people have a long and painful history of negative experiences with police in most places, including unfair discrimination in trials, the unwillingness of many jurisdictions to pursue and prosecute crime in black neighborhoods, police brutality toward blacks, and so on. Given the contemporary and historical racist context, there is no quick fix for white mental health professionals who want to gain the trust of their African-American clients. Immersing oneself in African-American culture and spending time in neighborhoods where African Americans raise their families, would enhance the cultural competence of white therapists. This would increase comfort levels for the therapist, but also, over time, would increase cooperation with black clients by signaling a genuine concern for African Americans.

There is another paradox that may be at work in clinical situations, whatever the race of the mental health professional. One study found that a sizable percentage of victims of violence are more secretive with therapists about violence, specifically because they fear that therapists would want to address violence problems once they are revealed (Jory et al., 1997). Hence, clinicians who announce their concerns about violence may find that their enthusiasm is an impediment to effective assessment with those clients who are resigned to suffering with abuse. Professionalism and competence are the hallmark of effective mental health professionals, but, in the case of violence, patience enhances competence and professionalism.

### *The Need for Multi-Modal Assessments Using Written Questionnaires*

Studies show that mental health professionals are more likely to learn about violence when they use a written questionnaire along with a clinical interview that is conducted in private with individual clients (Aldarondo, 1998). Because therapy can stir up powerful emotions, therapists should routinely reassess the risk of violence over the course of counseling, always taking the time to conduct a private interview that asks carefully worded questions about violence and also readministering a written questionnaire.

An analysis of the most widely used questionnaires is instructional about the multifaceted face of intimate violence, since questionnaires vary widely in who is asked to answer the questions, what questions are asked, and how the information is interpreted. Of course, mental health professionals should choose a questionnaire that fits their agency and the needs of their clients, but they will make this determination based on how the questionnaire fits their view of what constitutes abuse and violence.

In this section, I examine four violence assessment instruments that have been designed with very different ideas about what violence is and why mental health professionals should assess it. The instruments include the Danger Assessment Scale (DAS; Campbell, 1995) the Conflict Tactics Scale (CTS; Straus, 1979) and Revised Conflict Tactics Scales (CTS2; Straus et al., 1996), and the Spousal Assault Risk Assessment Guide (SARA; Kropp et al., 1998). I describe the Intimate Justice Scale (IJS; Jory, 2004) in the second section of this chapter. Readers who want to use these instruments should check out the primary publications describing their use and development.

**The Danger Assessment Scale.** The DAS was developed by Jackie Campbell, a nurse who studied homicides of battered women and male batterers to learn about the warning signs that would have predicted an impending homicide. In the first section of the DAS, the therapist asks the woman to use a calendar to mark the dates of all battering incidents in the last year. The calendar is used because the women have a tendency to "forget" how many times they have been physically assaulted in the last year. Campbell attributes this to psychological defenses that block the women's recollections. In the second section, the women are asked to mark "Yes" or "No" to 19 indicators that Campbell found to be associated with severe and lethal violence.

The DAS is designed to shock chronically and severely battered clients into recognizing the danger they are in by breaking through their psychological defenses. Questions like, "Does he ever threaten to kill you?" and "Do you believe he is capable of killing you?" can be very effective in stimulating a woman to take steps to protect herself when she was previously resigned to live complacently with sporadic beatings and chronic injuries. Because of its focus on chronic, severe, and lethal violence, the DAS is useful in agencies that serve severely battered women, such as hospital emergency rooms, police departments, prosecuting attorneys, and women's shelters. It is less effective with women who are dealing with less severe forms of violence, and would provoke unnecessary anxiety used as a violence screening instrument for women in general clinical practice. The DAS does not really address psychological abuse or minor forms of violence. The language of the DAS is oriented strictly toward heterosexual women, and would not be useful with gays, lesbians, and heterosexual males who are victims of abuse.

African-American women living in extreme urban poverty may be subjected to high rates of severe and chronic violence, and many of them have only marginal resources to combat the brutality of male intimates (Benson & Litton Fox, 2004). Many of these women have become so depressed that their rates of suicide are very high (Kaslow et al., 1998). The DAS is recommended for use by police social workers, emergency room physicians, shelter workers, and prosecutors who serve this group of women. Recognizing that these women may also be suffering from

depression, mental health professionals should assess and monitor depression levels and seek to protect the women from self-harm. Therapists who work with women who are experiencing less dramatic forms types of violence should consider a different type of written questionnaire.

The DAS is powerful because it looks at intimate violence through the eyes of its most affected victims, women who have been beaten so badly and for so long that they are confused about who is to blame and how vulnerable they are to being killed or permanently maimed. These women often suffer from chronic injuries and health problems: broken jaws and arms, burns, and cuts are common. Some of these women have impaired vision and loss of hearing from head traumas. Some suffer with vertigo, a type of chronic dizziness. Most are depressed, many are suicidal, and a few become homicidal as their entrapment in the silence of their own homes tightens around them and they see no way out of their suffering except to kill their tormenter. These victims are frustrating to mental health professionals because they are so needy, and yet so afraid of cooperating with clinicians who reach out to help them. The DAS has a proven track record with this group of victims, and is recommended for them.

**Conflict Tactics Scale and Revised Conflict Tactics Scales.** The CTS and CTS2 were developed by Murray Straus and his colleagues at the Family Violence Research Center at the University of New Hampshire. The CTS was designed primarily for epidemiological research on domestic violence, and has been used in dozens of studies in the last 25 years. The CTS2 added scales to assess victim injury levels, the presence of psychological abuse, and expanded the negotiation scales. The CTS looks at intimate violence through the eyes of researchers who wanted to free themselves from any particular bias. The guise of objectivity is, of course, a bias itself.

Both the CTS and CTS2 state: "Everyone has disagreements from time to time," and ask respondents to describe how they try "to settle their differences." The CTS has 18 questions, and the CTS2 has 39; but in practice the scales actually have 36 and 78 items respectively, because for each question respondents are asked first to describe their own behavior and then to describe their partner's behavior. The references to "disagreements," "settling differences," and the dual-questioning format reflects the belief that abuse is a form of conflict resolution and that the behavior of both individuals involved in a conflict is pertinent. The roots of the CTS and CTS2 have been controversial with those who view wife battering as rooted in male domination rather than conflict resolution.

The strengths of the CTS and CTS2 lie in their focus on specific behavior. Examples of such specificity include items like, "I accused my partner of being a lousy lover," "I slammed my partner against a wall," and "I twisted my partner's arm or hair." These questions bypass any theoretical bent or skew; and this underlies the wide use of the CTS in research on the prevalence of violence. In clinical settings, therapists can use the behavioral

aspects for documenting what acts have and have not occurred in the relationship. This behavioral focus can also be used to educate clients about the behavioral aspects of abuse. For example, many people view shoving between husbands and wives as benign and do not recognize that any use of physical force can lead to escalation and injury. Because the questions are behavioral and specific, the CTS is useful for documenting specific acts of violence in court reports.

When used in research, the CTS and CTS2 have a proven track record for documenting the prevalence of intimate violence in society, when violence is viewed strictly in behavioral terms. As for agency use with specific clients, there are problems. First, some CTS2 items may be too specific, such as "I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex." For those clients who are not involved in this kind of violence, these questions may be offensive.

For clinical use, the more serious problems of the CTS are in its underlying theory about what abuse is: focusing on specific behaviors may accurately measure the specifics of who pushed who or who insulted whom, but ignores patterns of male domination that thrive in abusive relationships. For many therapists, helping clients see domination patterns is critical to helping both victims and perpetrators break free from established patterns of inequality in their relationships. I compare this to studying organized crime, focusing strictly on their violent acts. Organized crime involves violence, but much more than that.

The subtle implication of the CTS that the behavior of both individuals is pertinent to abuse can harm those seeking help. Many victims remain in abuse situations because they have internalized feelings of blame for the abuse. Even the subtle suggestion that the abuse is "mutual" can have the unintended effect of immobilizing a victim in a dangerous situation. For this reason, some victim's assistance agencies have banned the CTS or eliminated questions posed to victims about their own aggressive behavior.

The CTS2 added scales for injury assessment and psychological abuse, and expanded the negotiation scale. This revision was done to improve the CTS in response to criticisms that the scale focused too much on behavior and not enough on the meaning and impact of violence. Unfortunately, the CTS2 kept the dual questioning format, asking respondents to rate first their own behavior, and then their partner's behavior. This may reflect the developers' continued emphasis on bidirectional or mutual violence. To be sure, women can be violent, and that their violence can be painful and harmful in relationships. However, women's violence is more likely to be in self-defense or in defense of her children, and less likely to cause serious injury. The differences between male aggression and female aggression can be graphically viewed in any police car, shelter, or hospital emergency room in the United States. For this reason, I caution against use of the CTS or CTS2 for clinical use, and applaud the CTS and CTS2 as research instruments.

**The Spousal Assault Risk Assessment Guide *(SARA; Kropp, Hart, Webster, and Eaves, 1998).*** A different approach to assessing violence focuses on identifying aggressors rather than victims of aggression. The SARA views intimate violence through the eyes of those in the criminal justice system who view it as a crime, and who are responsible for tens of thousands of prisoners, probationers, and parolees. As will become evident in this discussion, it is a sad reflection of discrimination and racism that the majority of men in the criminal justice system, starting with those arrested and ending with those executed, are African-American (Boyd-Franklin, 2003). Some of these criminal justice "clients" will commit intimate violence, given the opportunity, and most will not. The SARA was developed out of the need to make determinations about who is likely to offend and who is not.

The SARA was developed by researchers in forensic psychology who specialize in violence prediction. Violence prediction uses empirical research on offenders to create statistical models to predict future violence based on known risk factors. The SARA asks the professional who is conducting the assessment to rate the presence of 20 general risk factors, the presence of case-specific factors, and to determine whether any of the factors are "critical." Factors 1–10 relate to violence proneness in general and include past assault of family members, past assault of strangers or acquaintances, recent relationship problems, recent employment problems, victim and/or witness to family violence as a child, substance abuse, recent suicidal or homicidal ideation, recent psychotic or manic symptoms, past violation of criminal justice sanctions, and personality disorder with anger-impulsivity. Factors 11–20 relate to spousal violence in particular and include past physical assault, past sexual assault or sexual jealousy, use of weapons, escalation of frequency or severity of assault, extreme minimization or denial of spousal assault, attitudes that condone spousal assault, sexual assault history, and violations of "no contact" orders.

The SARA was designed for decision-making by personnel in criminal justice settings such as police officers, prosecutors, judges, parole and probation officers, and forensic psychologists. Meloy (2000) has argued that the "risk factor analysis" is superior to "clinical analysis" because therapists of various schools (i.e., social workers, psychologists, and psychiatrists) gravitate toward their own realm of expertise in assessing violence. Generally, psychiatrists consider biological variables, psychologists consider individual variables, and social workers consider social variables, like family status and poverty. Risk factor analysis purports to consider the broader picture of factors.

Similar to the DAS, the SARA is designed to identify only those offenders whose violence is chronic and severe. Although the CTS would identify a couple where the perpetrator had committed only minor violence (e.g., pushing and shoving), and would identify this even if the infraction had occurred only once in the last year, the SARA does not have this sensitivity.

Although the developers of SARA provide a manual to help raters understand the 20 factors, the instrument is designed to be used by individuals who work with offenders, who have access to their criminal histories, and other significant case knowledge.

Unfortunately, although African Americans represent a statistical minority in the United States, studies indicate that African Americans comprise the majority of those who are arrested for intimate violence, with blacks comprising up to 75% of all those arrested for intimate violence in some cities (Maxwell et al., 2001). These arrest rates reflect the racism and discrimination that plagues the African-American underclass with underemployment and unemployment, differential treatment in economic opportunities, and neighborhoods marked by high violence, substance abuse, substandard schools, and constricted avenues to life security.

At the societal level, using a rating system like the SARA, which is heavily based on factors known to be biased against males living in the African-American community (e.g., previous arrest records, unstable employment, substance abuse, anger problems), would seem to further extend institutional racism and to entrench black males in a mesh of blocked opportunities for productive and fulfilling lives. Instruments like the SARA that purport to be statistically objective but are based on statistics garnered in a racially biased system, give rise to anger and frustration among African Americans because of a reliance on statistical generalizations that put marginalized and disenfranchised individuals at a "statistical" disadvantage for rearrest and incarceration.

At the personal level of those who may potentially be attacked, however, the SARA gives rise to the same conflict that was revealed in the interviews of black women previously discussed (Rose, 2003). When a woman is being traumatized by a black male, it is further victimization of her when the criminal justice system, and the society as a whole, shows deference to her aggressor because he lives in a racist society. Like all victims, black women want to be protected, but they want protection in a system that is free of social injustice, where they are confident that their black brothers, fathers, uncles, cousins, and lovers will be treated fairly. We are not at that point in the United States, and this creates a distressing situation for black women who feel divided between loyalty to their African-American communities and to seeking protection for themselves.

## *How Good are Assessments for Intimate Violence?*

It is evident in examining these four instruments—the DAS, CTS, CTS2, and the SARA—that violence can be identified and assessed in a number of ways, and that there are a number of issues involved in understanding it. Some of these issues are inherent in the complexity of intimate violence; other issues arise because our understanding of intimate violence is still in its infancy. Some assessment issues are outside the scope

of this article, e.g., the coexistence of violence with alcoholism and substance abuse, the bidirectionality of violence between men and women, and women with battered woman's syndrome. These issues are critical in the African-American community, but they are too complex for this chapter.

One issue regarding assessment is whose eyes have the best view of violence? The DAS looks at violence through the subjective eyes of its worst victims, the CTS and CTS2 attempt to identify violence by asking couples specific behavioral questions, and the SARA looks at violence through the eyes of the criminal justice system. Whose eye is best for predicting intimate violence? An interesting study was conducted by Wiesz et al. (2000) in which they examined records from exit interviews at women's shelters. In the exit interviews, the women were asked to predict whether or not they would be physically assaulted by a husband, live-in boyfriend, or lover in the next 6 months. The study found that, based on follow-up data, the women had a 96% accuracy rating; only 4% failed to accurately predict their own abuse.

The Wiesz study, along with related studies, has led some in the domestic violence field to conclude that the single best predictor of impending violence is a woman's belief that she is, or is not, going to be attacked. This idea underscores a reality of intimate violence: women who confide in others that they worry about their husband or lover killing or beating them should not be dismissed as hysterical, but should be taken seriously. This situation was played out before the entire world in 1994 when it was learned that Nicole Brown Simpson had confided in friends and therapists that she believed her former husband, O. J. Simpson, a celebrity black athlete, was going to kill her. She was subsequently attacked and murdered, along with a male acquaintance, Ronald Goldman. Although Simpson was not found guilty in a court of law, many people believe that Nicole's prediction was accurate.

Of course, the disconcerting lesson from the Wiesz study and from Nicole Brown Simpson is that, despite the women's knowledge of impending attack, remedies were not in place to prevent the violence and the women were not able to thwart their attackers. The fact that women can be killed or maimed in their own homes is heartbreaking, but also consider the daily stress experienced by these women who live in chronic fear. Middle and upper class women may find short reprieves from this stress through a hotel stay, a day at the spa, or a short vacation with a friend. They own cars and have credit cards. They have extended family with extra bedrooms to get away for a night. They can afford medical care for their physical injuries, through a private physician. Women living in poverty, who are more likely to be African-American, cannot afford such reprieves. They often are required to get up and get off to work. When injured, they are more likely to bandage themselves at home, quietly and silently. When they seek medical care, they often sit through long waits in urban trauma

centers. All this adds to the secrecy; some poor women cannot afford to let anyone know they are being abused.

## *Is All Violence Alike?*

It is important to recognize that not all intimate violence is alike. Although this may sound obvious, it has not always been so. Cycle of violence theories that emerged in the 1970s hypothesized that male aggression, once initiated in a relationship, always escalates over time (Walker, 1979). By this thinking, the only difference between being pushed and being beaten was time, and the only difference between a man who grabs a woman and one who beats her was how far along in the cycle he had progressed. These ideas are no longer valid, however.

Studies indicate that intimate violence can be classified along the lines of its severity—minor, moderate, or severe (Greene & Bogo, 2002) or along the lines of its driving force—common couple violence or patriarchal terrorism (Johnson, 1995). Most violence probably starts small, but there is no evidence that all minor violence escalates in severity and there is evidence that some violence does not escalate over time. This is important knowledge because it keeps us from beating a fly with a sledge hammer, and gives hope that minor violence, when identified, can be addressed so as to avoid escalation.

The idea that all men who violate women are alike has also not received empirical support. Studies suggest that offenders fit into three types: family only batterers, dysphoric/borderline personality disorders, and generally violent or antisocial men (Holtzworth-Monroe & Stuart, 1994). Family only batterers use violence strictly with wives and children, and are viewed as inappropriately using aggression to achieve their goals. Family only abusers are more likely to be educated and employed, and more likely not to prematurely terminate treatment (as they have more to lose by quitting). Family only types are most amenable to successful outcomes in treatment programs.

Dysphoric/borderline personality types are emotionally unstable and often suffer from insecure attachment with their women. They are inappropriately jealous and controlling, and often decompensate into psychotic rages when they are separated from their women or when they feel that the women may terminate the relationship. Dysphoric/borderline types need long-term psychiatric treatment, but are unlikely to benefit from violence treatment because their emotional states are so powerful.

The generally violent/antisocial type is socially unstable, is likely to use violence both in and outside the family, and to use violence that is carefully calculated to achieve predetermined goals he has set for himself. This type is not usually amenable to violence treatment, and is most likely to be incarcerated. The abuse of this type is also more likely to be severe

and pervasive, including sexual abuse and rape, torture, psychological tormenting, and other types of violence.

The importance of assessing the type of male batterer is that it gives mental health professionals some basis for matching treatment to batterer type, if a valid assessment has been conducted. Generally, current treatments include Duluth-style educational groups, cognitive-behavioral therapy groups, and couples therapy. Unfortunately, metaanalytical studies of treatment effectiveness shows that, while all forms of treatment result in slight reductions of violence in the short-term, their record of effecting long-term cessation of violence is abysmal (Babcock & LaTaillade, 2000). Some studies indicate that no current mental health treatment for violence is more effective than incarceration, which is effective only while the offender is incarcerated; most re-offend following release (Maxwell et al., 2001). This should not be surprising, because our understanding of intimate violence is in its infancy. An analysis of treatment outcome studies is beyond the scope of this chapter, but such studies suggest that there is a need for programs that work. Given this conclusion, I will present an innovative approach to assessment.

## Intimate Justice Theory

Because new ideas for understanding intimate violence is warranted, I have been developing an approach over the last several years called intimate justice theory (Jory, 2004; Jory & Anderson, 1999; Jory & Anderson, 2000; Jory et al., 1997). The fundamentals of the approach are based on my experience as a police social worker and 20 years as a marriage and family therapist. The specifics of the approach were developed in a 5-year-long study of couples in a university research clinic. The approach is designed for couples where minor to moderate intimate violence is at issue, and not for antisocial or criminal offenders. Because this chapter focuses primarily on assessment, I will focus my discussion of intimate justice on assessment concerns.

### *What is Intimate Justice?*

Intimate justice is a theory about personal accountability in close relationships, and relates the dynamics of intimate justice to social justice, including social factors that promote violence like racism, gender dominance, class conflict, and the glorification of violence. Essentially, intimate justice is the idea that close relationships can be understood in terms of how individuals incorporate justice into their actions and attitudes. When individuals incorporate intimate justice, others feel fairly treated by them, even though there might be other issues, disagreements, or conflicts that are not related to fair treatment. In contrast, when individuals fail to

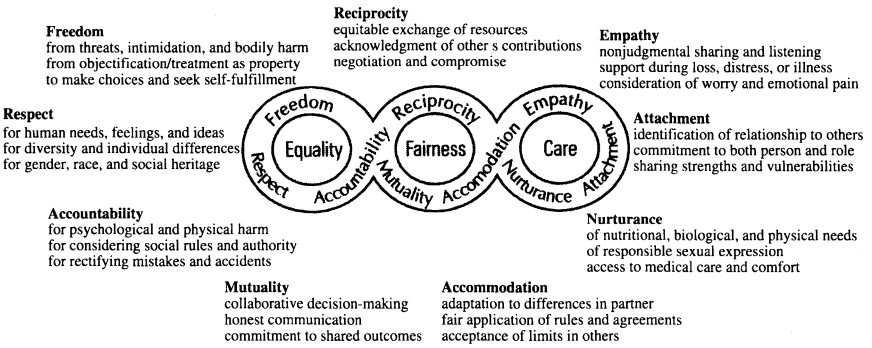


**Figure 4.1.** Dimensions and concepts of the *intimate justice* theory. Jory, Anderson, and Greer (1997).

incorporate intimate justice, their actions and attitudes traumatize others, and this failure is evident in the psychological and physical anguish experienced by those in their intimate environment. Hence, intimate justice is about personal accountability to others.

Intimate justice permeates practically all aspects of relationships, and its dimensions become evident by answering the question, "What ethical dynamics are essential for a perfectly just relationship?" The answer to this is found in three dimensions of close relationships.

- First, just relationships incorporate *equality*, which includes showing respect to each other, being accountable to each other, and allowing each other the freedom to make life-enhancing choices.
- Second, just relationships incorporate *fairness*, which includes honesty with each other, sharing the work and stress of daily living, and accommodating each other's personal limitations.
- Third, just relationships incorporate *care*, which includes empathizing with each other, nurturing the strengths of one another, and developing responsible attachment patterns rather than being selfish or exploitative.

Fundamentally, intimate justice is reflected in how individuals empower, disempower, and abuse power with others. By this thinking, power is not inherently problematic in relationships, but rather, individuals use power either to benefit or exploit others, and the impact of power can be beneficial or destructive. In this respect, caring is a form of power in close relationships because caring enhances the life possibilities of others, but also because caring is a powerful force in the life of those who choose to care. Therefore, responsible caring is a moral imperative in intimate relationships, rather than a mere emotion or personal preference. By this thinking, then intimate violence is not a single event, but involves patterns of attitude and action that result in trauma, exploitation, and betrayal.

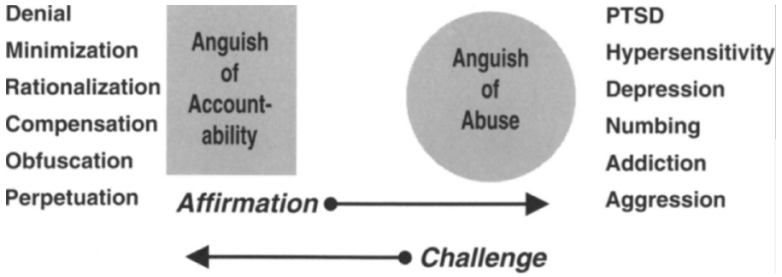


**Figure 4.2.** The *intimate justice* axiom. Jory and Anderson (2000).

## *The Intimate Justice Axiom*

An axiom is an idea that can be used to solve more difficult problems. The intimate justice axiom helps us understand the relationship difficulties of those who abuse others and those who are abused by them. According to the intimate justice axiom, there are two types of anguish in relationships—one is healthy and is called "the anguish of accountability," and the other is unhealthy and is called "the anguish of abuse." These are important concepts because they describe the experiences of our clients.

The intimate justice axiom is the idea that *to the degree an individual fails to embrace the anguish of accountability for his or her own actions, the anguish of abuse will be experienced by others in the emotional system.*

The anguish of accountability refers to the heavy weight of feeling evoked in those who embrace full responsibility for their own actions and attitudes. This means that doing "the right thing" toward those you love does not come easily; it is difficult, sometimes heart wrenching. You have to think about it; work at it. Essentially, the anguish of accountability is an emotional reaction to adopting an ethical stance.

I didn't make this up. The concept of anguish is rooted in modern ethical philosophy and refers to the human capacity not to be controlled by social and personal injustice but to make responsible choices in the face of life events. Jean-Paul Sartre (1957) described this by emphasizing that personal moral choices not only define individual character but also define the character of all humankind:

> "First, what is anguish? The existentialists say at once that man is anguish. What that means is this: the man who involves himself and who realizes that he is not only the person he chooses to be, but also a lawmaker who is, at the same time, choosing all mankind as well as himself, cannot help escape the feeling of his total and deep responsibility" (p. 18).

Individuals feel the anguish of accountability when they take responsibility for their past and contemplate changing their future. They also feel this anguish when they take responsibility for what they believe,

recognizing that some of their beliefs are more self-serving than true. This is important because so many of those who are violent self-servingly deny and minimize their destructive impact on others. Individuals also feel this anguish when they realize that they are personally accountable for behavior that is socially acceptable, but is nevertheless unfair. This is important because mistreatment of others is not only tolerated in our society, but is often encouraged.

The anguish of accountability is a psychological awareness, a necessary aspect of living an ethical, humane life. It is not a moral deficiency or a personal shortcoming. Feeling this kind of anguish is not fear. Fear is of some force outside yourself, of what harm might be done to you; the anguish of responsibility arises from within and is concern with what harm you have done or might do to others. It is not guilt, either. Guilt is a preoccupation with past failures and inadequacies; embracing the anguish of accountability means that you don't blame your past—you face your future and choose what kind of person you want to become.

## *Challenging Men With the Intimate Justice Question*

Assessment begins with the understanding that, where intimate violence is involved, the individuals are in substantially different places. The victim is struggling to unburden herself from the anguish of abuse and needs affirmation and support. The perpetrator is struggling to avoid the anguish of accountability and needs challenge to begin making better choices. By challenging, we learn about their attitudes toward personal responsibility and they assess themselves in the light of personal responsibility.

Challenging involves questioning their motives, exploring different ways of thinking, pointing out alternative courses of action, learning about abuse, and discussing social factors that foster violence such as racism, sexism, and glorified violence. Challenging helps abusers develop self-esteem, and is especially important when current self-esteem has been achieved outside the bounds of personal responsibility. The goal is to help abusive men assess themselves, not to punish them. Sensitive mental health professionals will find themselves appropriately providing support, even comfort, to these men as they struggle with self-assessment about making needed changes.

ACCOUNTABILITY. In assessment, we try to understand how the man relates to accountability. In a relationship, accountability means equal rights and responsibilities; equal partners demand similar levels of accountability. The ability to set limits on the behavior of one another provides feedback about expectations, limits, and personal responsibility and leads to a sense of control for both. The choice to make oneself accountable is to accept adult responsibilities, including self-awareness and self-control. The

acknowledgment that one is accountable signifies self-respect and respect for one's partner.

The intimate justice question was developed to assess how individuals think about accountability. This is usually done informally, in an interview, but is done gracefully and definitively rather than casually. To get the ball rolling, mental health professionals can ask them to consider the following hypothetical dilemma:

> What if something strange happened, and you were suddenly transformed into your partner. Knowing how you treat her, how would you feel? What would it be like being in an intimate relationship with you?

Individuals who routinely think about personal accountability in relationships usually answer this question easily. Abusive men have more problems with it. Some try to avoid the question. Some pretend not to understand. Some extol their virtues and degrade their partner. Mental health professionals listen for entitlement. In this context, entitlement encompasses a belief that violence is permissible for adults, particularly adult males, in some family situations. Entitlement is at work when the man is unwilling to say that violence against women is wrong *in all situations*. Entitlement is assessed by ascertaining the situations where the man views intimate violence as acceptable. For some it is permissible, "if they won't do what you tell them to." For others, it would be acceptable "if you found her in bed with another man." In contrast, these same men often believe that violence against them is unacceptable in all situations.

Entitlement encompasses the belief that "I am not only entitled to mistreat my partner, but I am entitled not to be questioned about it." Many abusive men have never examined how they treat others, and they resent anyone else doing so. This is evident in the bewildering ways they deny, minimize, and justify their verbal tirades, threats, slapping, and beatings. When pressed, they often describe their abuse as something that "happened" rather than something they did.

**Respect.** Mental health professionals also try to assess how these individuals think about respect toward others. Human respect is grounded in the intrinsic worth of every human being and is innately connected with a healthy sense of self-worth. In a relationship, respect engenders emotional closeness by empowering the couple to look out for one another's interests. Unfortunately, abusive men generally equate respect with submission, obedience, and deference rather than intrinsic human worth. They view respect less as something you give others and more as what you gain when others are afraid of you. Lashing out, intimidating, and humiliating establish a hierarchy in which they view themselves as "on top." Many of them feel good by running down their partner.

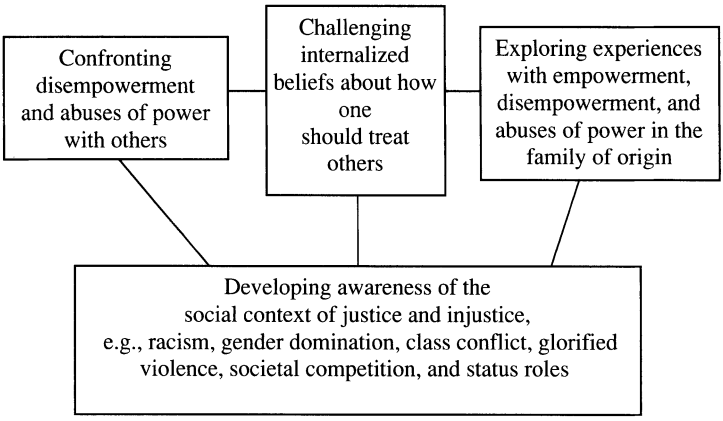


**Figure 4.3.** Applications of the *intimate justice* theory. Jory, Anderson, and Greer (1997).

FREEDOM. It is also important to assess how these men feel about freedom for their loved ones. Freedom in a relationship means diversity is valued, personal preferences are respected, variations in psychological and physical development are appreciated, and personal accomplishment is rewarded. Virtually all relationships are restricting in some way because relationships require sacrifice. In a fair relationship, restrictions are freely negotiated to fit the values, needs, and desires of the individuals. If restrictions are too limiting, individuals feel unfairly constrained. If restrictions are too lax, the individuals feel disconnected and unattached. If restrictions are not uniformly applied, individuals feel manipulated or exploited. Does he require his partner to put his needs and personal preferences ahead of her own? Does he acknowledge her accomplishments? Does he punish her when she doesn't do what he wants? Does he treat her as property? Does he control his jealousy or does he allow his jealousy to control her?

In my studies, accountability, respect, and freedom in relationships have shown themselves to be critical indicators about the propensity for violence and abuse. Two aspects have come to light when the intimate justice question has been used with black males, though. First, some black males feel entitled to harm others because they feel hurt themselves by racial discrimination. These are men who feel hopeless about their plight, and who see no rewards for treating others respectfully. In specific situations, their discouragement is supported by real experiences with racial discrimination. As mental health therapists, we must respect the experiences these men have had, and will continue to have, with racial hatred and bigotry. They are real experiences and they hurt. Most of all, we must emphatically denounce racial discrimination and do so in moral terms: Racial discrimination is morally wrong. In my experiences, sliding down the slippery slope of ignoring racial hatred is counterproductive to asking others to "do the right thing."

In the bigger picture, however, there is another slant. Some black men have not given themselves—and others—the opportunity to reap the rewards of living a moral life. For some, their indignation over social injustice took hold of their self-concept in early stages of psychological and social development. They gave up their hopes and dreams too early in life, and allowed their anger to guide them through relationship after relationship. It is important to emphasize to these individuals that we are accountable for our own actions and attitudes even in the face of social injustice. Violence contributes to the injustices they abhor, especially when it is directed toward those they love. For many, accountability begins when they consider that they are contributing to the problems they abhor. This is not an easy stance to accept, and mental health therapists need to support these men as they struggle with the question, "What kind of person do I choose to be?"

### *Assessing Victims of Violence Using the Intimate Justice Scale*

For victims, a more formal assessment is indicated that includes a written questionnaire and a private interview. The Intimate Justice Scale (IJS; Jory, 2004) is a written questionnaire that was developed for screening potential victims of intimate violence in clinical and educational settings. The scale is made up of only 15 questions and can be completed in about 5 minutes. The scale uses language that is gender neutral, and can be used with clients in many types of intimate relationships. In many clinics, the IJS is used routinely with all clients at initial assessment to see how they relate to patterns known to be associated with violence. With some clients, the scale is readministered throughout the course of treatment as trust builds. When the IJS suggests the possibility of abuse, further evaluation is warranted to assess frequency and types of violence, injuries, and severity.

The IJS was developed in a study of 80 women who were in clinical treatment for various problems. Twenty five percent of the women were of a racial minority; about 10% were African-American. Some of the women had been abused, some not. The study found that scores on the IJS had an 88% success rate in distinguishing women who had experienced no violence in the last year from those who had experienced moderate or severe violence. Case by case analysis indicated that the IJS was effective with women of color.

The IJS asks clients how strongly they agree with 15 items that describe how their partner usually treats them. Responses range from 1 to 5, with 1 indicating, "I do not agree at all" and 5 indicating, "I strongly agree." The minimum possible score is 15, indicating little likelihood of abuse. Scores above 30 are associated with clients who are experiencing moderate abuse. Scores above 45 are associated with severe abuse. Any item where a client marks a 3 or higher indicates a concern, and should be discussed with the client in private.

## The Intimate Justice Scale

Read each item below to see if it describes how your partner usually treats you. Then circle the number that best describes how strongly you agree or disagree with whether it applies to you. Circling a one (1) indicates that you do not agree at all, while circling a five (5) indicates that you agree strongly. Your answers are confidential and will not be shared with your partner.

| | I do not agree at all | | | | I strongly agree |
|---|---|---|---|---|---|
| 1. My partner never admits when she or he is wrong. | 1 | 2 | 3 | 4 | 5 |
| 2. My partner is unwilling to adapt to my needs and expectations. | 1 | 2 | 3 | 4 | 5 |
| 3. My partner is more insensitive than caring. | 1 | 2 | 3 | 4 | 5 |
| 4. I am often forced to sacrifice my own needs to meet my partner's needs. | 1 | 2 | 3 | 4 | 5 |
| 5. My partner refuses to talk about problems that make him or her look bad. | 1 | 2 | 3 | 4 | 5 |
| 6. My partner withholds affection unless it would benefit her or him. | 1 | 2 | 3 | 4 | 5 |
| 7. It is hard to disagree with my partner because she or he gets angry. | 1 | 2 | 3 | 4 | 5 |
| 8. My partner resents being questioned about the way he or she treats me. | 1 | 2 | 3 | 4 | 5 |
| 9. My partner builds himself or herself up by putting me down. | 1 | 2 | 3 | 4 | 5 |
| 10. My partner retaliates when I disagree with him or her. | 1 | 2 | 3 | 4 | 5 |
| 11. My partner is always trying to change me. | 1 | 2 | 3 | 4 | 5 |
| 12. My partner believes he or she has the right to force me to do things. | 1 | 2 | 3 | 4 | 5 |
| 13. My partner is too possessive or jealous. | 1 | 2 | 3 | 4 | 5 |
| 14. My partner tries to isolate me from family and friends. | 1 | 2 | 3 | 4 | 5 |
| 15. Sometimes my partner physically hurts me. | 1 | 2 | 3 | 4 | 5 |

Rather than asking about specific acts of violence, the IJS measures ethical dynamics that are associated with psychological abuse and violence. For example, item 4, "I am often forced to sacrifice my own needs to meet my partner's needs," can be answered only by considering the

long-term balance of reciprocity in the relationship. Some items ask respondents about the ethical beliefs of their partners, regardless of whether the beliefs are behaviorally enacted or not. For example, item 12 asks respondents to agree or disagree with, "My partner believes he or she has the right to force me to do things." In some relationships, the use of force may not be overtly enacted, but the threat of force covertly permeates all aspects of the relationship. The most important item in regard to physical violence and injury is item 15, "Sometimes my partner physically hurts me." The client is not asked whether or not the hurt is intentional, because many violent men convince their victims that their injuries were an accident and were not intended.

### *Affirmation, Assessment, and a Private Interview*

As previously discussed, it is essential that violence assessment includes a private interview along with the written questionnaire. In conducting interviews, mental health professionals should be aware that posttraumatic stress disorder (PTSD) colors every aspect of the assessment process with abused women. Women experiencing PTSD usually blame themselves for feeling angry and think their path to healing is in changing their feelings rather than their abuser changing his actions. They are often hesitant to disclose their abuse because they feel responsible for making their men beat them. They often think they are harming their man by focusing on their own needs. They are usually ambivalent about wanting to end the relationship and would view themselves as failures if they were to do so. Although blaming themselves, however, they usually hope for their men to change. They are, therefore, usually distrustful of those who want to help, fearing that they will be asked to simply forgive their men with no change by them. They may become suicidal or self-destructive, engage in high-risk sexual behavior, dangerous eating habits, or self-mutilating behavior. If they abuse children or other vulnerable persons, mental health professionals must take steps to protect the children and others they may be harming.

Unlike perpetrators, who respond to challenge, women experiencing the anguish of abuse respond to affirmation. Affirmation is an active, definitive, and consistent message from the therapist to the traumatized woman that she is a worthy person who is not responsible for the trauma or its implications. Through affirmation traumatized women can be expected to develop a greater sense of control, experience enhanced will and hope, and benefit from emotional catharsis. In an environment of affirmation, assessment involves helping these women understand trauma and their psychological reactions to trauma. This understanding should help them clarify, in a practical way, the anguish they are feeling and make informed choices about how to regain control of their lives. When these women are hypersensitive, aggressive, or withdrawn; or when they drink too much;

or seem overly compliant or resistant; or sink into depression, an effective assessment considers how this fits with their history of interpersonal trauma and how to help these women stop blaming themselves.

For example, consider a woman who becomes severely depressed with a controlling, dominating, and aggressive husband. He blames her for bad cooking. He locks her out of the house as punishment. He tells her she is a lousy lover. And then he slaps her. Although the mental health professional might not intend it, this woman is likely to hear a diagnosis of depression as one more problem for which she is to blame. Recognizing this, an effective mental health professional will present the diagnosis of depression to her in a way that affirms her. The therapist might explain that depression is a typical reaction in her situation and will help her trace the roots of her depression to specific incidents or patterns of domination. Did she feel more depressed after her husband locked her out of the house? What is it like when her husband slaps her around for the way she peels carrots or puts the butter on his toast? The diagnosis of depression would most effectively be delivered in a message of affirmation by telling her, "The depression indicates you are a perfectly normal person in perfectly abnormal circumstances."

Affirmation means avoiding stances that blame women for their plight. Questions like, "Where did you learn to tolerate this kind of behavior in a man? Why didn't you walk out the first time he started these angry outbursts? Don't you realize things will get worse until you get tough and take control?" might be offered with the best of therapeutic intentions, but we must consider how judgmental this can feel for someone who is already carrying a heavy burden of self-blame.

Mental health professionals who practice intimate justice in their personal and professional interactions with others will be most proficient at using this set of ideas for understanding violence in the lives of their African-American clients—whether dealing with those who are the brunt of abuse or the transgressors. As humans, we need more sensitivity to justice issues, at all levels of society, from the bedroom to the boardroom, from Hollywood to Harlem. None of us is immune from social injustices that surround us every day; and everyone deserves intimate justice.

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# Chapter 5

# Domestic Violence and the Black Church: Challenging Abuse One Soul at a Time

Tricia B. Bent-Goodley

It was almost 5 years since they were married. Ryan was a church-going woman. She had been so ever since she was a child. Having grown up in the Black Church, she valued the importance of supporting her community, being a faithful wife and mother, and honoring her commitments. Accepting that the man is the spiritual leader of the home, she humbled herself to his direction and vision and attempted to support her husband—this black man who was highly regarded and well respected in the community. They had a beautiful home, a wonderful child, and belonged to numerous social and professional organizations. Fundamental to all of this was her belief in the word of God and her religious values. That was why she found herself confused and perplexed. How could God love me and let me go through so much pain? Didn't "He" see the bruises, the blood, the torn skin or the scabs from previous abuse? Couldn't "He" see the broken spirit, the phony smiles and make-up used to hide the residue of violence? She had prayed. She was anchored in the Word. She was saved. She didn't wish bad things against her husband. She stayed the course, took the faith walk, and continued to support this man who said he loved her, yet was emotionally, physically, and psychologically abusive. So, where was God? Had "He" forgotten me? Doesn't it matter that I'm one of the faithful? Or has God turned "His" back on me because my husband is the Chair of the Deacon's Board?

Ryan was one of my clients as an early social worker. She was a middle-aged, upper-middle-class African-American woman with a visible job and a highly successful husband. She was articulate, well kept, and engaged

with her church, school PTA, and professional organizations. Yet, the violence in her home was hidden. She found no recourse in her family who could not understand why someone so successful and attractive stayed in "that type" of relationship. Her friends, many of whom were single, encouraged her to work it out because she could not maintain her current lifestyle on her income alone. Her spiritual allies told her to pray, stay faithful, help this "brother" through what was believed behavior linked to the pressures of being a black man in a hostile, racist society. She came to me to figure out what she should do. Two years later, after a horrible abusive incident that left her paralyzed on one side of her face, she took her child and moved into her car. She refused to go into a shelter. When her family found out about her situation, her brother allowed her to stay with him until she was able to plan her next move.

There was little in the domestic violence literature that prepared me to address this client's situation. Yet, the importance of the Church as a resource was undeniably evident. She reached out to a mental health professional as a last resource. For 5 years, she sought counsel within her Church and its religious leaders. Something within her told her that the answers were incomplete. Her decision, after 7 years of abuse and eventual paralysis, was to walk away. Yet, many women choose to stay, feeling confused and even violated by the mixed messages of forgiveness, faith, and the meaning of loving someone despite being abused, violated, and demeaned in an intimate relationship. These women are particularly vulnerable to the rash vestiges of abuse and yet, there is minimal information on how to engage faith-based organizations to diminish or end the paradox of violence when individuals are connected to places of worship. This chapter reviews the available information and shares the perceptions of members of the religious community on this subject, gathered from an exploratory study.

## Literature Review

Domestic violence is a pervasive, underreported problem. Prevalence of the problem is not well understood. Some studies report that less than one million people experience domestic violence annually (Rennison & Welchans, 2000; Tjaden & Thoennes, 2000); although other data suggest that domestic violence impacts nearly 5 million women annually (National Center for Injury Prevention and Control, 2003). Regardless, the data indicate that 80 to 90% of survivors are women. Nearly one in three women experience violence from an intimate partner each year. Prevalence data is limited to reported cases and thus, are suspected to be an inaccurate representation of actual domestic violence rates. Still, we know that 33% of female murder victims in the United States were killed by an intimate partner compared to 4% of male victims, accounting for the deaths of 1247

women in the year 2000 (Rennison, 2003). Domestic violence is not confined to race, class, sexual orientation, or religion. Abused women "account for 14 to 28% of women attending primary care clinics, 4 to 17% of women attending prenatal clinics, and approximately 30% of women with nonmotor vehicle injuries presented to emergency departments" (Rodriguez et al., 1996, p. 153). Survivors of domestic violence are also more likely to contract HIV as compared with women in nonviolent relationships (Kalichman et al., 1998; Wyatt, et al., 2000). In addition, often used as a means of self-medicating themselves, substance abuse levels are higher for survivors of domestic violence as compared to women in nonabusive relationships (Hampton, Senatore & Gullotta, 1998).

## *African Americans and Domestic Violence*

Before going further, it is important to recognize that the majority of African-American relationships are violence-free. Yet, domestic violence does present serious issues for the African-American community to consider. Domestic violence was cited as the number one public health issue for African-American women by the National Black Women's Health Project (Joseph, 1997). African Americans and Native Americans were found to experience domestic violence at higher rates than other populations (Tjaden & Thoennes, 2000). African Americans experience more serious and lethal injuries and higher victimization rates than other groups because to domestic violence (Tjaden & Thoennes, 2000). This is possibly due to limited service availability, lack of cultural competence by service providers, and the fear of the consequences of reporting violence (Bent-Goodley, 2004b). African-American children are more likely to be removed from the home due to domestic violence than white children despite similar circumstances (Bent-Goodley, 2004a).

Domestic violence clearly has an adverse impact on African-American families due to several issues. African Americans experience numerous barriers to services due to lack of cultural competence (Bent-Goodley, 2005; Gondolf & Williams, 2001; Hampton & Yung, 1996), the impact of racism and discrimination (Richie, 1996; Williams, 1999), the impact of myths and stereotyping (Hampton & Yung, 1996; West, 1999), and racial loyalty (Bent-Goodley, 2001; White, 1994).

## *Lack of Cultural Competence*

Lack of cultural competence is a barrier to receiving services because it does not allow a practitioner to detect abuse, sustain engagement with a client, and develop an efficient working relationship because the client may not feel that the intervention is reflective of his or her experience (Bent-Goodley, 2005). Not limited to the practitioner's race and ethnicity,

cultural competence addresses the approach and systemic representation of populations receiving services.

### *Racism and Discrimination*

Racism and discrimination serve as a barrier to services because it causes mistrust of systems and fear of reaching out for assistance even when it is needed. For example, mandatory arrest laws have been found to disproportionately impact African Americans despite the fact that the law requires an arrest regardless of race, class, or gender (Mills, 1998). Yet, African Americans are more likely to be arrested and prosecuted for domestic violence than whites in similar circumstances (Mills, 1998). The consequence is that African Americans feel that the law enforcement system treats them unfairly and is working against them instead of helping them. So, although there are a number of African Americans who call for police intervention to stop abuse, there are many who choose to sustain the violence because, in their eyes, the alternative of calling the police can make the situation worse.

### *Myths and Stereotypes*

Myths and stereotypes of African Americans negatively impact help-seeking behavior. For example, shelter workers have turned African-American women away from services believing that African-American women are stronger and better capable of fighting an abusive partner than a white woman (West, 1999). Other myths within the African-American community also deter help seeking. The myth that domestic violence does not occur in the African-American community because African-American women do not stand for abuse can make a woman feel as if something is wrong with her. Thus, she chooses to be abused rather than expose her situation.

### *Racial Loyalty*

Racial loyalty has been defined as when "the African-American woman may withstand abuse and make a conscious self-sacrifice for what she perceives as the greater good of the community but to her own physical, psychological, and spiritual detriment" (Bent-Goodley, 2001, p. 323). This decision is often reinforced by family, friends, and the church that reinforces the need for her to protect her man and serve as a buffer between the inequity of society and the safety of the home (White, 1994). She is encouraged to stay silent about the abuse so that negative stereotypes of African Americans are not reinforced or further characterized.

The complexity of these barriers cannot be understated (see Bent-Goodley, 2001). Both external and internal forces work against African

Americans seeking help to stop domestic violence. Still, many come forth to seek help. Increasingly indigenous institutions are becoming aware of the adverse effects of domestic violence in the African-American community. As part of this consciousness, the African-American church is beginning to consider its place in stopping violence in the home.

## Religion, Domestic Violence, and the Black Church

Spirituality can be defined as "the sense of the sacred and divine" (Martin & Martin, 2002, p. 1). "Religion focuses on an external expression of faith" (Bent-Goodley, in press). The connection between spirituality and domestic violence is being recognized and studied (Hassouneh-Phillips, 2003; Senter & Caldwell, 2002). Yet, creating faith-based interventions that address domestic violence are limited. Little is known about the experiences of church folk with domestic violence. Although most denominations have official policies on domestic violence (Ammons, 1999), churches continue to send overt and covert messages that provide fertile ground for violence in the home (Love, 1998; Wolff et al., 2001). For example, narrow interpretations of Bible passages have allowed some to overtly use scripture as a tool to harm and disempower women. Being told to obey one's husband and tying that imperative to scripture is hurtful, manipulative, and can place women in greater harm of violence. Being told that women have no place in ministry or denying women decision-making opportunities within the Church sends a covert message that women are "lesser than" men and not worthy of equal respect and equal treatment in the home or the church.

Despite these messages, women of color turn to their faith-based community to address domestic violence before they consult mental health, social service, law enforcement, or medical providers (Adams & Fortune, 1995; Bent-Goodley, 2001; McClure & Ramsay, 1998; West, 1999). Consequently, faith-based communities wield power and influence to both prevent domestic violence and intervene when it has occurred. Given this situation, the author undertook an exploratory study of African-American churches in the DC metropolitan area to better understand their views of this problem.

### *Methodology*

The study used a mixed-method approach that included use of a survey instrument and focus groups. A 46-item instrument was administered to church leaders and congregants in three African-American churches of medium to large sizes. The instrument included content on demographic data, the Wife-Abuse Inventory Scale (WAIS) Scale, and Sex-Role Perception (SRP). This survey had been utilized previously with a similar

population (Bent-Goodley, 1998), and a panel of experts reviewed the survey to ensure relevance to this population. The survey took 10 minutes to administer and was coded with numbers as opposed to names to ensure anonymity.

## *Participants*

There were a total of 122 participants that completed the survey: 62% were women and 38% were men.

EDUCATION. Most of the participants had some college experience or an advanced college degree. Fifty-six percent of the participants had a Bachelor's or Graduate Degree. Six percent possessed a doctoral degree. Nearly one quarter had experience in college but did not possess a college degree. The remaining 13% had a high school diploma.

INCOME. Over one-half of the participants had incomes over $30,000, with nearly 30% of these participants having incomes over $50,000 a year.

EMPLOYMENT STATUS. Sixty percent of the population was employed, 21% were retired, 11% were students, and the remaining 8% were unemployed.

AGE. Eleven percent of the participants were under the age of 18. Fourteen percent of the participants were between 18 and 34 years old. Fifty percent of the participants were between the 35 and 55 years old, and 25% of the participants were over the age of 65.

ETHNICITY. Eighty-five percent of the participants were born in the United States and 15% were born in the Caribbean, specifically Jamaica and Trinidad.

MARITAL STATUS. Forty-percent of the participants were married; 49% were single, never married; and 11% were divorced.

CHILDREN. Forty-five percent of the participants had no children, 12% had one child, 18% had two children, and 25% had more than three children.

DENOMINATION. Nearly 40% were Baptist, 22% were Protestant, 21% were African Methodist Episcopal, 3% were Catholic and the remaining 10% did not identify a religious affiliation.

RELIGIOUS ACTIVITIES. The vast majority of the population was heavily engaged in church activities, indicating 80% of the participants being involved in a minimum of weekly service activities in the church.

ORGANIZATIONAL AFFILIATIONS. The majority of the participants were affiliated with outside professional, community, and civic organizations. Fifty-seven percent of the participants indicated participation in some sort of group outside of the church. Of those, 19% were affiliated with a fraternity or sorority, 20% belonged to a professional organization, and 10% were part of a community service organization.

CLASS AS A CHILD. Nearly one-quarter of the participants self-identified as growing up in poverty and 75% self-identified as growing up in middle-class homes.

### *Participant's Experiences with Domestic Violence*

Nearly one out of three participants had experienced physical abuse from an intimate partner. Over one-third of the participants had experienced emotional or psychological abuse. Twenty-seven percent of the participants identified as having been physically abusive toward an intimate partner. Over half of the participants indicated having intervened to stop a domestic violence situation. Almost 30% of the participants said that they knew of a man being abused.

### *Attitudes and Beliefs Toward Domestic Violence*

The participants had a consistently low tolerance for domestic abuse. The majority agreed that domestic violence was not an appropriate solution to resolving discrepancies. For example, 85% of the participants disagreed with the statement that "women could avoid being abused by their partners if they knew when to stop talking." Ninety-three percent of the participants disagreed with the following two statements: "occasional violence by a man toward his partner can help maintain the relationship" and "a sexually unfaithful woman deserves to be abused by her partner." Ninety percent of the participants disagreed with the statement—"a woman deserves to be abused if she keeps reminding her partner of his weak points." The vast majority of the participants felt that more should be done to respond to domestic violence. Ninety-one percent of the participants agreed that "social agencies should do more to help women who have been abused" and 86% agreed that "the law should protect women if their partner abuses them."

### *Sex-Role Perception*

The majority of the participants had a less rigid sex-role perception as compared with a sizable number of participants that had a more rigid sex-role perception. For example, 83% disagreed with the statement that "it would be better for American society if fewer women worked." Seventeen

percent of the respondents did agree with this statement, indicating a more rigid sex-role perception. Differences in sex-role perception were more pronounced with the following two statements. Seventy-two percent of the respondents disagreed with the statement that "it is much better for everyone involved if the man is the achiever outside the home and the woman takes care of the home and family." Nineteen percent, nearly one out of five, of the respondents agreed with this statement. Although 63% of the respondents disagreed with the statement that "a preschool child is likely to suffer if his or her mother works," 37% (over one-third) agreed with the statement. Consequently, while the vast majority of the participants indicated a flexible sex-role perception, there was a considerable number that evidenced more rigid sex-role perceptions. Additional information illustrating sex-role perception and its relevance to the church was discussed during the final meeting with the participants.

The participants stressed the need for religious intervention to prevent and diminish domestic violence and expressed a belief that churches had a role to play to eradicate domestic violence. Emphasizing that there appears to be an increasing reliance on the criminal justice system to address domestic violence, the respondents felt that the church needed to become more involved before police intervention becomes necessary. The respondents also felt that the church had a greater chance of being able to aid in the healing process to prevent further abuse as opposed to other systems because of their regular access to the population and credibility in the community.

> *"Churches definitely have a role to play to stop domestic violence. Somehow everything goes to the criminal justice system. It's crazy. We can't just keep locking people up. Churches have to be involved [in] this. The [criminal justice] system can't heal these people. They just keep going in and out. We can do something about that."*

The participants stressed the need for greater awareness of how spirituality and religion are used as both strengths and barriers to addressing domestic violence. One participant shared the story of an aunt killed due to domestic violence.

> *"We all knew what was going on. No one wanted to get involved because they were married and, as they say, that's married folks business. He stopped letting her go to church because he swore she was having an affair with the pastor. Everybody knew what was going on. He shot her dead. [pause] Everybody knew but they didn't do anything.*

The participants also acknowledged that the church needed to address sexism within its ranks. Acknowledging that sexism leads to a devaluation of women, the respondents recognized differential treatment of women that leads to perceptions that women are less capable than men to make decisions and serve as leaders in the church. Simultaneously, the participants

stressed that women are the backbone of the church, particularly with regard to ensuring the functioning of church initiatives and financial contributions through consistent tithing and attendance and participation at church events. Yet, their human capital and financial contributions do not equate to power and can promote images of women as being less valuable and weaker than men. Although not seen as promoting domestic violence, these images provide fertile ground for abusive behavior toward women.

Moderator: *"You've mentioned some frustration with all that you do and contribute to the church that you don't feel that women are treated the same."*
Participant 1: *"That's true but what can you really do about it? We just don't talk about the sex [gender] issue. We all know it's there but what are you going to do about it, really?"*
Moderator: *"What if you all picked a Sunday and didn't come to church. I bet the impact would be felt then."*
Participant 2: *"Girl, what are you trying to get started in here?"* [laughter]

An additional barrier to addressing domestic violence in churches was the perception that gossip would occur. Several participants addressed that people often choose not to say anything due to fear that the incident would be "spread all over the church." The participants shared that churches are like family systems no matter the size. Emphasizing that there are numerous interrelationships and confidentiality is sometimes broken. The threat of gossip being spread poses a challenge for someone seeking assistance.

*"It's like a big family and trust me, word can get around... and fast. Why would I tell someone something so personal and then hear my business out on the street ten minutes later? It's hard to tell when something will come up and when it won't. That still doesn't stop people from telling their business."*

There was even fear expressed with bringing up the topic of domestic violence. The participants acknowledged the importance of domestic violence but feared being labeled if they initiated dialogue about domestic violence. Many of the participants thanked the researcher for bringing up the topic so that it could be discussed without any one church member being labeled or singularly associated with the issue.

## *Male Code of Conduct*

The men in the group shared the ways in which men interact and are guided by a perceived code of conduct. Consequently, other men may not confront another man perpetrating abuse because he recognizes that he may not be doing the right thing in his own relationship. It was emphasized that the abusive behavior may go unaddressed not because there is an agreement with the behavior but because the men feel it was hypocritical to say one thing and do another in their relationship.

*"How am I going to say something about what another brother is doing if I'm stepping out on my wife. A lot of times it's not that you agree with what he's doing. None of us justifies beating on a woman or anything like that but there's an understanding between brothers that women don't understand. I'm not going to call someone else out if I'm being less than perfect in my own situation."*

## Lessons Learned

There were a number of lessons learned from engaging the African-American church on this topic. Namely, one must understand the full African-American experience to address this issue in the church, and one needs to understand the Black church as its own distinct system.

### *The Full African-American Experience*

Conducting research in Black churches provides a tremendous opportunity because they can include diverse ethnic groups, professions, educational backgrounds, and other social categories under one place of worship. Consequently, respecting the diversity within the population is critical. Having an understanding of the diversity within the congregation is critical to addressing abuse. Many of the participants were from suburban areas and coming back into the urban environment for church. Some of the participants were of Caribbean ancestry. This rich diversity presents a wonderful opportunity for conducting research.

The discussion often turned to other topics as a means of discussing domestic violence in the African-American community. For example, the enslavement of African people and its vestiges currently within the African-American community was brought up in a number of training sessions. This dialogue required that the researcher understood these connections and could be responsive to the issues presented. Contemporary challenges to African-American male-female relationships were also discussed. Again, being able to openly discuss these types of issues was fundamental to the success of the initiative. Being able to understand communication styles was also critical to fostering fruitful dialogue. The researcher understood church vernacular and cultural forms of expression, such as storytelling, used to illuminate a point.

### *Understanding the Black Church*

In order to work with the Black church, you need to understand how it is organized, its structure, the many functions it serves, its importance, and its power. For example, the author had to make official contact with the Pastor directly. Pastors would be less responsive if the Graduate

Assistant called. Calling the Pastor directly was seen as demonstrating respect. Equally important, it is essential to maintain the use of surnames, again as a sign of respect.

One needs to be prepared to use multiple forms of communication. When in doubt, calling and following-up with a letter is of key importance. Reminders are always critical as Pastors are extraordinarily busy ministering, trying to keep the church viable and potentially working a day job.

The researcher must be able to link the discussion of domestic violence with the priorities of the church. For example, if there was a HIV ministry, the researcher highlighted connections between domestic violence and HIV within the African-American community. If there was an established interest in children and families, the researcher highlighted connections between domestic violence and child removal from the home. Making these linkages helped church members see how domestic violence was connected to their priority areas.

Some may suggest that engaging this population denotes expertise in the Bible. This researcher admitted to not being a Biblical scholar upfront. Acknowledging that there were others better versed in the Bible allowed for greater dialogue, appreciation from the groups, and a sense that we could all learn from the dialogue.

Finally, working with churches is not a 9 to 5 proposition. One must be available to attend Sunday services, weekday evening Bible study, and other religious events. People have to see your face a few times in different settings to feel that you are trustworthy, truly interested in the community, and not simply generating research findings.

## Implications

Churches are opportune places to address the insidiousness of violence in the home. Equal work needs to occur among other religious groups, such as those in the Muslim, Jewish, and Hindu populations. Working with churches provides opportunities to connect with diverse populations and to engage an equal partner that has a rich body of knowledge to share. This research provides greater awareness of how middle-class African Americans think about domestic violence. It also provides indications of a paradox between rigid sex-role perception, sexism in the church, and knowing that domestic violence is wrong. We need to know more about the interconnection and complexity of these issues.

Men need to be better engaged as partners to end domestic violence. Helping to find ways of addressing silent rules of male codes of conduct is necessary to finding comprehensive solutions to end abuse. The men in this study knew that domestic violence was wrong. The men essentially wanted ideas of how to challenge this code of conduct in a realistic manner.

Churches have options to address domestic violence. Invite local domestic violence experts and service providers to educate congregation members about domestic violence. Conduct sermons on domestic violence or invite individuals to preach about domestic violence throughout the year. Organize a local conference or initiate a larger discussion with faith-based leaders about what can collectively be done to address domestic violence. Conduct health fairs that include information sharing about domestic violence. Examine or hire an outside consultant to explore patterns of involvement in decision-making, representation, and equal involvement in activities according to gender. Some churches have even gone on to open shelters and develop programs for child witnesses of domestic violence.

## Conclusion

The church is a fertile ground to help end abuse. We can reach diverse groups of African Americans through churches. Churches are often willing to partner with social workers and other professionals when they are approached in a collaborative fashion and once they know the person can be trusted. Faith-based organizations provide distinct opportunities to address domestic violence. Truly, we can save one soul at a time through partnership and mutual respect, and faith in a Higher power.

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Chapter 6

# The Art of Healing: An Afrocentric Helping Guide for Practitioners Working with African-American Families Who Experience Intimate Partner Violence

Selena T. Antá Rodgers

*Black roots chanting violence in silence were those yester-years, a time before today, when a WOMB-man-ist reminisced about walls that buried gory family secrets behind the 'door of no return'.*

*Survivors of ancestral revolts, victims of facial numbness, and perpetrators of projected power and control lashings went to sleep dreaming of private tribal dances and awoke to nightmares of mental battles—residue that drummed beats of black and blue rhythmic and generational violence—cycles of emotional, flesh and spiritual beatings. Imprisoned by "isms", 911 calls, 2 by 4 walls & child welfare mandates that separated them all; they did bids & ruminated about scars that spoke, bathed & breathed on their own. Their time was cemented by memories that birthed lifeless wombs & wounds during moonrises escaping across the sun, eclipsing tears, and tunes that echoed—suffering in SILENCE . . .*

*A mom, a dad, her husband, his wife:*
*An African family 400+ years from native soil,*
*living in America is transmitting shackled rage*
*NTU (Universal Life Force) spoken word on a*
*journey of no more violence!*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

## Introduction

To understand the above poem within the context of why current treatment and intervention models are ineffective when working with some African-American families who experience partner violence, one must give specific attention to an African-centered perspective, defined as quality of thought and practice rooted in the cultural image and human interests of African people from their own perspective (Asante, 1980). Descendants of Africa have had to contend with complex and mediating factors, beginning with the violent and ruthless ripping from Africa, continued with the violence during the middle passage, right up to the reinforcement of discriminatory acts of modern-day systems, (e.g., the mental health system, the child welfare system, and the criminal justice system). To date, the worldview differences, absence of historical comprehension regarding the effects of institutionalized racism and the lack of skills obtained in nonblack institutions have created systems that impede African Americans from reporting physical abuse to police more than their white counterparts, (Asbury, 1987; Hampton & Young, 1996). These are factors contributing to many African Americans refusing existing treatment and interventions. Families who experience intimate partner violence (Gelles, 1997) are often exposed to humiliation and mistreatment (Pierce, 1995) by these systems when assistance is sought. This guarantees that they are less likely to seek vital services in times of need (Bell & Mattis, 2000).

Interpersonal violence refers to child abuse, sibling violence, intimate partner violence, and elder abuse (Gelles, 1997). In this chapter I propose a solution to ineffective treatment and intervention models that is focused on an African-centered perspective predicated on traditional Afrocentric ontology, which has interconnectedness (Myers, 1991) and spirituality (Pinkett, 1993) as its core tenets. Chapter goals are to introduce existing treatment approaches for intimate partner violence, assert reasons for the limitations of these models in treating African-American families, and provide a guideline for practitioners, using principles from the *Nguzo Saba*, (the seven principles), pronounced (*En-GOO-Zoh-Sah-BAH*), which will be illustrated by *The Art of Healing*. *The Art of Healing* is an Afrocentric, strength-based training outline, a helping guideline and an interdisciplinary Rites of Passage program. *The Art of Healing* offers recommendations for best practices, programming, future research, and culturally specific goals and resources for practitioners (see Appendix).

The origins of *Nguzo Saba* (the seven principles) (see Table 1), springs from the *Kawaida* Theory (Swahili term for that which is traditional or customary) (Johnson, 1991) of ideology and practice:

> The basic concepts of Kawaida centered on the contention that the key crisis in Black life is the cultural crisis, e.g. a crisis in views and especially, values. The need, thus, is for a cultural revolution which would break the monopoly

**Table 1. The Seven Communitarian African Values. (Karenga, 1988; 1993)**

*Umoja (oo-MOE-jah)* Unity—
Striving and maintaining unity in the family, community, nation, and race.

*Kujichagulia (koo-jee-cha-goo-LEE-ah)* Self-determination—
Defining, naming, creating, and speaking for ourselves from a strengths-oriented perspective as opposed to being incorrectly defined or spoken for by others.

*Ujima (oo-JEE-mah)* Collective Work and Responsibility—
Working collectively toward resolving problems and maintaining our community.

*Ujamma (oo-JAH-mah)* Cooperative Economics—
Building and preserving our stores, shops, and businesses in an effort to jointly enjoy the profits.

*Nia (Nee-AH)* Purpose—
Making a concerted attempt to build, develop, restore, and cultivate our community in order to reclaim the inherent greatness of our people.

*Kuumba (koo-OOM-bah)* Creativity—
Thinking of and executing ways to improve our community both intrinsically and aesthetically.

*Imani (ee-MAH-nee)* Faith—
Having steadfast determination and belief in our Creator, our people, ourselves, parents, teachers, and leaders, all of whom have struggled for racial justice and equality.

> the oppressor has on Black minds and begin to rescue and reconstruct Black history and humanity in their own image and interests (Karenga, 1993 p. 173).

In 1966, Karenga introduced *Nguzo Saba*, which became the training basis for many schools, Rites of Passage, and other programs. The *Nguzo Saba* is best known as the values of Kwanzaa, an African-American holiday celebrated by many African communities (Karenga, 1988; 1993). According to Karenga (1993), the *Nguzo Saba* has been identified as the minimum set of African values that African Americans need to rebuild and strengthen family, community, and culture, and become aware of the social force in the struggle to control their destiny and daily life.

Based on the above assertion, the *Umoja* (unity) and the *Imani* (faith) principles are linked to the Afrocentric tenets of "interconnectedness" and "spirituality." For some African-American families, who experience partner violence, the principles of *Umoja* and *Imani* principles offer a cultural foundation for addressing ineffective treatment and interventions.

## Prevalence and Incidence of Intimate Partner Violence Among African Americans

> *Souls unjustly returned to the land blocked by yesterdays'... "Willie Lynch" ings—*

*"HUSBAND KILLS WIFE, CHILD, & HIMSELF."*
*Lifelines covered by hollow ground, unable to flourish like*
*Baobab trees rooted in oneness, or to reaffirm links and quilted lineages.*
*Anew were we!*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

According to the American Medical Association (1992), partner violence usually results from the abuse of power or the domination or victimization of a physically less powerful person by a physically more powerful person. Partner violence is recognized as a serious social problem jeopardizing the safety of families. As Lee notes (2002, p. 530), "the deleterious impact of intimate partner violence has been documented along a number of health-related dimensions, including acute injuries, somatic health complaints, diminished psychological functioning, and decrements in other social role domains, including occupational, interpersonal, and parental functioning."

Partner violence is a broad range of violent behavior between victims and offenders who are emotionally related (Gelles, 1997; Hampton et al., 2003). Most situations of partner violence involve a husband against a wife, including offenses such as assault and harassment (Division of Criminal Justice Annual Report, 1999), which often take place within the home (Fraser, 1999). More recently the description of partner violence is expanding to include female and male situations. For example, Johnson (1995) and Johnson and Ferraro (2000) identified *mutual violent control* as a couple pattern in which the husband and wife are controlling and violent.

The dynamics of partner violence have been researched in recent years as awareness of the problems associated with this behavior have increased. According to the Bureau of Justice Statistics (2003), about three in 1000 households include a member victimized by an intimate partner. Approximately eight to 10 inmates serving time for intimate violence have injured or killed their victim (Bureau of Justice Statistics, 2001). About 40% of inmates in jail for intimate violence were on probation, parole, or had a restraining order at the time of the violent attack on a partner (Bureau of Justice Statistics, 2001). It is the privacy and isolation of households in the United States and the lack of social supports that reinforces an environment of continued violent assault (Gelles & Straus, 1988).

The Bureau of Justice Statistics (2003) report that racially diverse groups were less likely to report intimate violence to police because the victims stated it was a "private or personal matter": in other words, family matter. Victims also "feared reprisal" by the partner and simultaneously reported a need to "protect the offender" (Bureau of Justice Statistics, 2003). Daly et al. (1995) assert that African-American women are more likely to view their physical abuse from the perspective of racial oppression. It is the view of Hampton et al. (2003, p. 541) that "women may perceive that African-American men who are frustrated by virtue of their exposure to

historical and contemporary patterns of racial and gender oppression, and who in response to such oppression adopt manhood roles that condone resorting to violence as a means of resolving disputes are at risk of committing partner violence." Thus, African-American women are likely to view battering as the African-American male's displaced anger and aggression in response to racism and his struggle to assume or maintain economic and other social roles typically expected of males in America (Hampton et al., 2003).

Partner violence negatively impacts families across race, ethnicity, and class, but for African Americans the elevated risk of violence is compounded (Coker, 2003). Estimates from the National Crime Victimization Survey suggested that between 1993 and 1998 both African-American men and women were victimized by partners at significantly higher rates than persons of any other race (Rennison & Welchans, 2000). Black females experienced partner violence at a rate 35% higher than that of white females, and about 2½ times the rate of women of other races. Black males experienced partner violence at a rate of approximately 62% higher than that of white males and about 2½ times the rate of men of other races (Rennison & Welchans, 2000).

The high incidence of partner violence is further magnified by socioeconomic factors (Bell & Mattis, 2000). Rennison and Welchans (2000) reported that women, being black, young, divorced or separated, earning lower incomes, living in rental housing, and living in an urban area had higher rates of partner victimization between 1993 and 1998. Of the total number of intimate violence cases reported, half of all offenders convicted of intimate violence are in jails or state prisons and had been drinking at the time of the offense (Bureau of Justice Statistics, 2001). Alcohol-related problems among both male and female partners were important predictors of partner violence across racial/ethnic groups (Campbell et al., 2002). This is especially true for African Americans where alcohol-related problems remained the strongest predictors of partner violence (Caetano et al., 2001; Cunradi et al., 2000).

## Current Treatment and Intervention Approaches

*Shackled minds marginalizing*
*tides that quench cultural thirsts for empowering interventions—*
*INTENTIONAL UNCONSCIOUSNESS . . .*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

Crime-centered approaches (Coker, 2003) and psychoeducational and cognitive-behavioral interventions represent efforts to address partner violence (Aldorondo, 2002; Gondolf, 2004). Feminist scholars insist that a key construct of partner violence is the power imbalance necessary for abusive

behavior and victimization to occur (Dutton, 1994; Pence & Paymar, 1993; Walker, 1989; Wolfe et al., 1997). Sociologists argue that patriarchy is just one variable in a complex constellation of causes (Gelles, 1993; Straus et al., 1980). This broader view has resulted in modified interventions that attempt to address the wider social context of abuse (see Hoff, 1999).

It is this author's contention that treatment approaches remain fragmented and do not include the totality of the African-American experience. The preferred model for working with families who experience partner violence remains one that emphasizes *separate but treatable* treatment and intervention models. That is, women receive individual services separate from men based on their being victims (Straus, 1994); males are likely to be separated and incarcerated at higher rates due to being perpetrators (Coker, 2003); and children have increased risk of being separated from families and placed into foster care for witnessing violence that occurs between their mother and father (Nicholson v. Scoppetta, 2004). Thus, *separate but treatable* services sustain oppressive outcomes among African-American families who interface with mental health, child welfare, and criminal justice systems.

## Limitations of Treatment and Intervention Models with African-American Families Who Experience Intimate Partner Violence

*Attempts to cacophonize Mother Afrika's harmonious tunes*
*have become discordant generational paradigms.*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

Regardless of the essential need for treatment among African-American families who experience partner violence, some interventions evoke resistance to treatment (Boyd-Franklin, 1989). The issues of partner violence involve social-historical, institutional, community, family, and individual-level experiences (Bell & Mattis, 2000). Hines & Boyd-Franklin (1982) posit that "the system" has negatively affected African Americans. In her book *Black Families In Therapy*, Boyd-Franklin (1989) uses the term "multisystems" to describe the, social, political, socioeconomic, and other environmental conditions that impact African-American families. Supporting this argument, Pinderhuges (1982) described the ways in which slavery and oppression in the United States have merged with racism and exclusion, resulting in the reinforcement of problematic African-American families who experience partner violence. I believe there is a relationship between ineffective treatment and intervention models for African-American families and the reinforcement of discriminatory acts and institutionalized racism within the mental health, the child welfare, and the criminal justice systems.

## *Mental Health System*

Many scholars have observed that most mental health treatments have been developed with and primarily for middle-class whites in the United States (Brodsky, 1982; McGoldrick & Giordano, 1996; Ponterotto & Casas, 1991). There is also agreement among scholars that using the "one size fits all" treatment models when working with families who experience partner violence, is ineffective (Gondolf & Williams, 2001; Peffley & Hurwitz, 1998; Williams, 1998; Williams, 2000).

The participation of African Americans with "traditional" mental health services has been detrimental to the family. They have been reluctant to seek formal assistance due to cultural insensitivity and racism on the part of mental health professionals (Fowler & Hill, 2004; Mays et al., 1996; Raj et al., 1999; Short, 2000). In addition, often African-American clients are not self-referred, but mandated for treatment by schools, courts, police, and child welfare agencies (Boyd-Franklin, 1989). This has created a stigma toward receiving counseling in the African-American community because of the fear of unwanted and unnecessary medication for behavioral and population control and governmental abuse of clinical files (Robinson, 2000). Marimba Ani (1994) in his book, *Yurugu: An African-Centered Critique of European Cultural Thought*, undertook research to empirically support the belief that these fears arise out of past genocidal behavior such as the Tuskegee Experiment (1932–1972), in which black men with syphilis were monitored, but not treated, in a program that involved the compliance of both doctors and government officials.

The therapist moving from harmful to becoming helpful requires clinical skills that recognize black heritage (Alford, 2003), and the experiences of African-American families within systems that persist in using *separate but treatable* approaches in instances of partner violence.

The use of the genogram and ecomap can assist with this goal. The genogram or family tree displays essential family information, patterns and relationships over generations (Bowen, 1978; Guerin & Pendagast, 1976; McGoldrick & Gerson, 1985). Hence, if one agrees that violence is learned, then one must consider that violence has *transgenerational consequences* (DeGrury-Leary, 2001). These attitudes and behaviors resulting from trauma can be passed down unconsciously from generation to generation (DeGrury-Leary, 2001). For example, Joy DeGrury-Leary (2001), has developed a theory of *Post-Traumatic-Slave Syndrome*, which explains the etiology of many of the adaptive survival behaviors in African-American communities. The use of the ecomap (Hartman, 1978) can assist practitioners to identify hypotheses that emerge about family (kin and nonkin) networks and their experiences with partner violence. These observations can be used as steps toward a unified healing process of nonviolence.

## *Child Welfare System*

*Separate but treatable* reflects the punitive approaches to child welfare and interpersonal violence that result in the removal of children from mothers who are abused (Nicholson v. Scoppetta, 2004). Kurtz et al. (1993), suggest that parents who neglect their children report high levels of marital conflict and interpersonal difficulties. Bent-Goodley (2004) reports that women identified differential treatment by the child welfare system as a major impediment in seeking help for domestic violence. Increased numbers of children entering foster care, due to neglect in instances of reported *failure to protect* cases, contributes to African Americans' heightened sense of mistrust when seeking services related to partner violence for fear of children being separated from family. The statistics are staggering for African-American children in out-of-home care. "In 2002, African-American children accounted for 42% of all children in foster care, although they only represent 17% of US children" (Roberts, 2002, p. 8). Recently, The New York State Coalition Against Domestic Violence reported that the New York State Appeals Court decided that exposure of a child to domestic violence is not presumptive grounds of neglect or necessary removal (Nicholson, v. Scoppetta, 2004). This ruling is vital because it strengthens the direction of a movement that sets precedent in keeping families intact, while providing services to ensure a no-violence environment.

## *Criminal Justice System*

*Separate but treatable* in crime-centered approaches is reflected in polices such as "mandatory arrest" that has created a disparate negative impact on men and women of color (Maguigan, 2003; Richie, 2000) and increased the risk of further entanglement in the criminal justice system (Coker, 2003). Current crime-centered approaches (Coker, 2003) exemplify a response that intersect and perhaps are driven by "racially *coded* issues of crime" (Peffley & Hurwitz, 1998, p. 7). Further, "white Americans (inaccurately) tend to see the typical criminal as being black" (Peffley & Hurwitz, 1998, p. 14). In addition to sanctions that create stigmatization (Braithwaite, 1989), the overrepresentation of black males as prisoners, probationers or parolees, is another confirmation of the bias of the American justice system toward African Americans. For example, white men who are reported to the criminal justice system for spousal abuse are more likely to be referred to the mental health system. African-American men are more likely to remain in the criminal justice system (Beckett & Coley, 1987; Hacker, 1992). In 2003, there were 3405 black male prisoners per 100,000 black males in the United States in prison, compared to 1231 Hispanic male inmates per 100,000 Hispanic males and 465 white male inmates per 100,000 white males. It is estimated that 18.6% black males compared to 3.4% white males, will enter a prison sometime during their lifetime (Bureau of Jus-

tice Statistics, 2001). Black males remain overrepresentated in the criminal justice system, and underrepresented in literature that discusses their potential contributions within the family system. Moreover, "perceptual and knowledge bases about African-American males will need to be reconstructed by practitioners with the assistance of their Black male clients." (Rasheed & Rasheed, 1999, p. 90)

Additionally, there has been an increase in the number of women arrested for partner violence. Women accounted for 14% of violent offenders, an annual average of about 2.1 million violent female offenders (Bureau of Justice Statistics, 2001). Battered women who become defendants often find that their past history of victimization gets erased when they are labeled perpetrators (Osthoff, 2002). The majority of these women report that "when they seek services from battered women's advocacy programs, they often are turned away" (Osthoff, 2002, pp. 1529–1530).

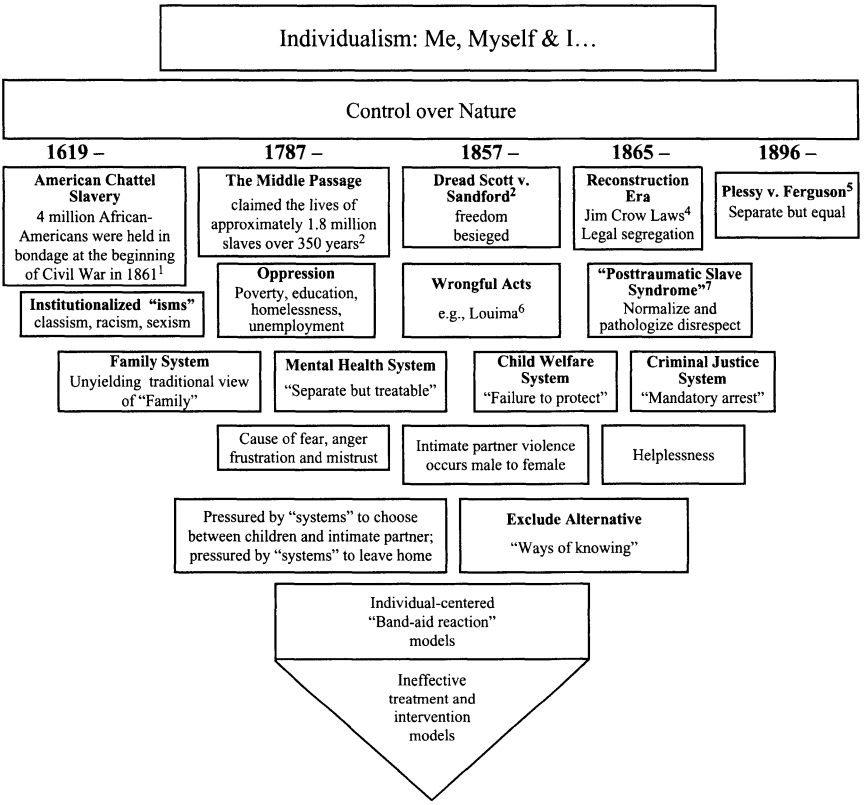
## Intimate Partner Violence in African-American Families: A Tug-of-War Between Theorectical Worldviews

*Systems amd isms weaved patches of*
*awareness ribbons for*
*domestic incident and retribution rituals—*
*TRANSFORMATION...*
*Reconstructing hues of darkness that bind*
*PEACE and empowerment*
*—RITES!*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

This section explores "the practitioners' use of 'self' and how values, perception and cultural similarities and differences have an impact on ones frame of reference" (Boyd-Franklin, 1989, p. 95). The Afrocentric orientation to coping and resolving problems using interconnectedness has survived in a dominant Western culture (Daly et al., 1995). The Eurocentric Worldview defines the concept of "self" as a hierarchal and mechanistic framework (Baldwin, 1985; Dixon, 1976; Nobles, 1976) (see Table 2). That is, culture that embraces rationality, material achievement, and individualism (Daly et al., 1995). In the Afrocentric Worldview, the concept of "self" is the study of the universe as an interdependent totality and regarded as a sense of "Oneness" and "In Harmony with Nature" (Akbar, 1975; Erny, 1973; Mbiti, 1970; Nobles, 1972) (see Table 3). Interconnectedness promotes the understanding that all things are related, and provides the foundation for all human interactions through harmony and positive relationships (Alford, 2003).

In his book *Afrocentricy: The Theory of Social Change*, Asante (1980) offers evidence of the conceptual framework of Afrocentricity or

**Table 2. An Eurocentric Paradigm: ineffective treatment and intervention models with African-American families who experience intimate partner violence.**

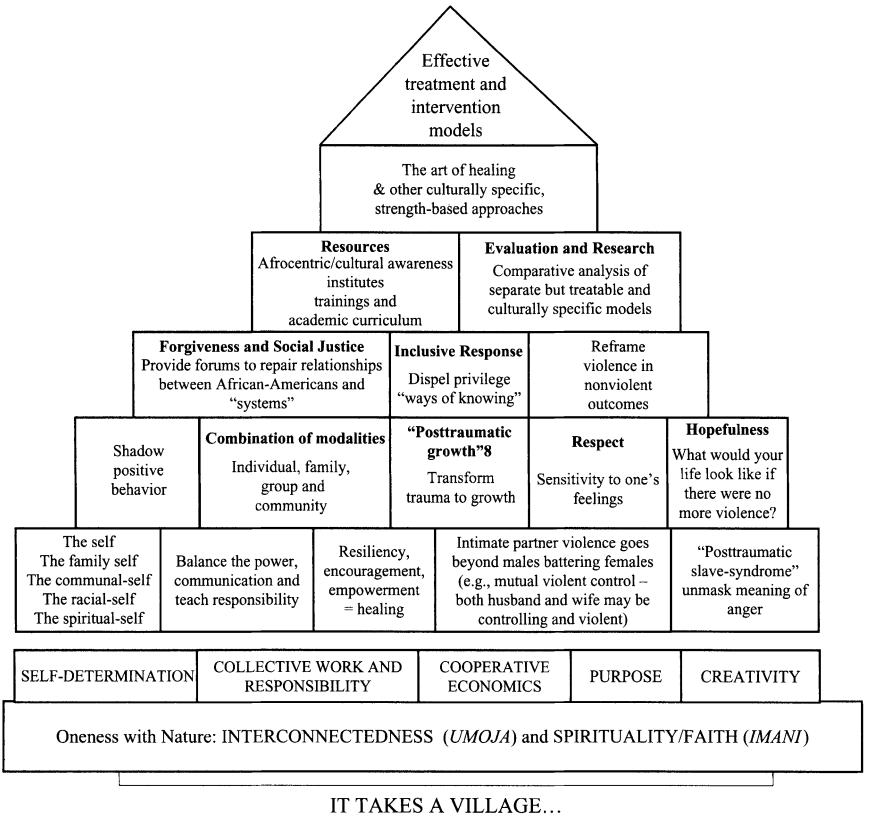



African-centeredness. Baldwin et al. (1991) uphold Asante's (1980) Afrocentric Worldview by acknowledging the value of unity, cooperative effort, and collective responsibility. This Worldview is the basic principle of the African ethos—

> "Survival of the group." Not only is the human being an internal part of his or her ecological setting, but is also harmoniously bound to his/her bio-social community or group. These guiding principles of the African cosmology influence all aspects of African life. The African ethos endorses the value of unity, cooperative effort, collective responsibility and concern for the community among black people" (Baldwin, Brown & Hopkins, 1991 p. 157).

Therefore, it is important to contextualize partner violence among African-Americans based on these social-cultural dynamics. It is from these Afrocentric viewpoints that African-American women may feel a conflict between ensuring their personal safety and the need to protect

**Table 3. An Afrocentric Paradigm: effective treatment and intervention models with African-American families who experience intimate partner violence.**




African-American men based on racial loyalty. Bent-Goodley (2001, p. 323) defines racial loyalty as an African American's decision "to withstand abuse and make a conscious self-sacrifice for what she perceives as the greater good of the community but to her own physical, psychological, and spiritual detriment." Richie (1996) states that African-American women are convinced by community members, family, friends, and/or abusive partners that black men are at particular risk of death and rape if imprisoned. The overrepresentation of incarcerated African-American males reinforce this fear. African-American women are expected to sustain the abuse to protect the family, maintain the relationship, and spare the larger community the embarrassment of the partner violence they experience (Bent-Goodley, 2004).

Practices that include Afrocentric core values usually have not been incorporated into treatment and intervention models. In contrast to the Afrocentric Worldview, the Eurocentric Worldview suggests:

> ... "control over nature" represents the relentless propensity of the European self or the European corporate personality toward achieving mastery and domination over the universe... the principle is operationalized through oppression, suppression, and repression. In addition, it emphasizes the individual and highlights a dualistic notion of the individual as separate and independent from the social group or collective... the individual's identity can be forged independently of the group identity which is primarily responsible for the individual's existence... (Baldwin et al., 1991 p. 145).

Eurocentric frameworks to explain partner violence have tended to emphasize psychological models with particular focus on individual characteristics (Straus, 1994). As discussed by Raj et al. (1999), this inadequacy is evidenced by reviews of the psychological literature on batterer and victim personality profiles. Eurocentric accounts of partner violence among women would argue that women who decide to stay in abusive relationships are "helpless, dependent, or ill..., which results in their being less likely to make decisions that help keep them physically safer" (Mills, 2003, p. 66). However, research has failed to find any consistent pattern of individual psychopathology either in men who batter or in women who are abused (Alexander, 1993; Hotaling & Sugarman, 1986; Ptacek, 1984).

## Cultural Competence and Afrocentric Approaches

*$100 Reward—WANTED: A WOMB—MAN,*
*imprisoned by systems*
*for stealing herstory and history*
*kidnapped*
*Red, black, & green pride and*
*PERSERVERANCE—Priceless...*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

Given the need to identify, from a nondeficit perspective, in which the dominate culture does not set the standard (Daly et al., 1995), the remainder of this chapter shares developing Afrocentric interventions and presents a treatment modality in the Appendix that practitioners can use when working with African-American families who experience partner violence. Mattis (2000) contends that in order to contribute to efficacious therapeutic work with African Americans it is important to address issues of bonding, attachment, connectedness, and issues of cultural competence (Mattis, 2000). Kawaida's theory "defines culture in the broadest sense to equate it with all the thought and activity of a given people or society" and focuses on the seven areas (spirituality, history, social organization, economic organization, political organization, creative production and philosophy) of culture as core areas of analysis of critiques and correctives (Karenga, 1980, pp. 16–17).

Social support from family and friends and spirituality are thought to be particularly relevant resources to African-Americans (Billingsley, 1992; Thomas, 2001). Although mental health professionals have historically neglected social support and spirituality as culturally relevant factors in clients' ability to cope with psychosocial problems (Fowler & Hill, 2004), they are becoming increasingly open to the idea of nontraditional interventions that aid in families' emotional well-being (Hines & Boyd-Franklin, 1996). For example, Bergin (1991) notes that such spiritual values among practitioners might include sensitivity to others' feelings, responsibility for one's actions, fulfillment and satisfaction, self-discipline, forgiveness, and a sense of purpose.

Interconnectedness and spirituality are also prevalent within other diverse groups and immigrants. For example, similar to the two core Afrocentric tenets of spirituality and interconnectedness, is the traditional Native American cultural view of harmony as being one with natural forces (Sutton & Nose, 1996). Practitioners would benefit from utilizing diverse examples of spirituality and other cultural values that are important to families who experience partner violence.

If practitioners are to provide effective services for African-American families who experience partner violence, there is a need for models that incorporate an understanding of the role of race, class, culture, immigrant status, sexual orientation, and religion in the cycle of violence (Fowler & Hill, 2004; Richie, 1996; Williams & Becker, 1994). The legacy of slavery and the history of racism experienced by African Americans and other people of color in this country and the refusal to acknowledge the lasting effects of these unconscionable acts is the largest failure of traditional treatment and intervention approaches. If alternative models are unwilling to address issues that influence partner violence in African-American families, the insidious cycle of violence will continue. Service providers need to be aware of effective techniques and service models for working with African-American families. African Americans often view "culture as the complex pastiche of symbolic forms (e.g., folkways, mores, language, religion, gender roles, childrearing practices, rituals, metaphors, medicines and healing practices, music, and fighting behavior, etc." (Bell & Mattis, 2000, pp. 516–517). Therefore, "these values and beliefs are essential components of any treatment plan for this cultural group" (Boyd-Franklin, 1989, p. 22).

A review of the literature suggests that Afrocentric interventions with African-American families in urban communities are beginning to evolve (Harvey & Hill, 2004). Approaches such as African-American Rites of Passage cultural programs are a valuable beginning, and can be traced to Ancient Kemet (Egypt). Rites of Passage within Egyptian society required neophytes to undergo an elaborate, intense, and difficult process before they could be considered eligible for initiation (Alford, 2003; Haich, 1974; Warfield-Coppock, 1992). The belief of the interconnectedness of human

life, nature, and spirituality was pervasive in ancient Africa; they practiced their beliefs through ceremonial tradition of RITES (see Alford, 2003).

Interconnectedness/Umoja (Harvey & Rauch 1997) and spirituality/Imani (Warfield-Coppock, 1992) are incorporated into African-American Rites of Passage programs (Alford, 2003). For example, Harvey and Rauch (1997) implemented the Nguzo Saba through Umoja and Imani. At each meeting with youth and staff, they began with forming a unity circle (holding hands, saying a nondenominational prayer, and pouring libation out of respect for ancestors, and requesting their ancestors presence at the sacred event). African affirmation cannot be separated from the spiritual force that exists in every African person, as they sing and make music to protect their families and raise their children (Ani, 1994, p. 2).

Alford (2003) reported findings from a Rites of Passage program offered for children placed in foster care. Several themes emerged from Alford's (2003) qualitative study. In summary, Alford saw improved self-esteem, spirituality, a greater appreciation for African-American history, and respect and racial pride regarding ideas about relationships with women.

Harvey and Hill (2004) analyzed an African-American Rites of Passage program in the context of family. These researchers examined the effects of an Afrocentric youth and family Rites of Passage program for at-risk youths (ages from 11 to 14 years) and their parents. Findings suggest that youths showed gains in self-esteem and knowledge of the dangers of drug abuse. Parents demonstrated improvements in parenting skills, racial identity, cultural awareness and community involvement. Participants from this study were referred from the criminal justice system and local schools. Further, 80% of the parents felt that the program increased ties between them and their sons, and 71% of the youth felt the same way (Harvey & Hill, 2004).

There remains a disconnection between traditional treatment models and Afrocentric perspectives. As a result, practitioners are not able to effectively develop attainable treatment outcomes with African-American families who experience partner violence. Presently, no empirical studies evaluating Rites of Passage programs with African-American families who experience partner violence were located. It is important to address this gap. Although scholars like Baldwin (1984), Robinson and Howard-Hamilton (1994), and Alford et al. (2001) state that Afrocentric approaches are integral to maintaining positive mental health for African Americans, others hold a different view. Frisby (1993); and Reed et al. (1997) question the use of these approaches for addressing problems facing African Americans. For example, some might view these programs as a form of religion. However, in this chapter, spirituality is distinguished from religion. Spirituality is internally and experientially defined, transcends the tangible, and connects one to the whole, which includes the universe and all organisms (Robinson, 2000). It refers to the perception of and interaction with

the transcendent and sense of inner strength in daily life (Underwood & Teresi, 2002). This author views spirituality as a coping response that can aid in the process of transitioning from partner violence to a violence-free environment.

In comparison to spirituality, religion refers to an institutional affiliation guided by a shared system of beliefs, rituals, and behaviors (Derezotes, 1995). Indeed, in some churches, individuals have used biblical references to legitimize the use of physical coercion as a strategy for getting women to submit to the authority of men in their lives (Bell & Mattis, 2000).

## Conclusion

It is unthinkable that services remain fragmented and ineffective, further afflicting African-American families as a result of absent and salient cultural-specific treatment and intervention models. This deficiency is a core reason why some programs have not had success (Gavazzi et al., 1996). This chapter is a call for effective treatment and intervention models that reinforce existing strengths within African-American families (see Appendix). Because of their generalist skills and sensitivity to issues of diversity, social workers can be equipped to initiate and lead efforts to reduce racist, classist, and ethnocentric barriers (Harvey & Rauch, 1997, p. 31). Social workers and other practitioners have an opportunity to implement promising, strengths-based treatment interventions to meet the needs of diverse populations.

## APPENDIX

### The Art of Healing: An Afrocentric Helping Guide for Practitioners Working with African-American Families who experience Intimate Partner Violence

*i am*
*impregnated with purpose.*
*Awoke, resting on the shoulders of the African Diaspora.*
*Cradled by experiential colonics that cleansed savage disorder.*
*We are flourishing NTU shadows and synergy on a journey to Hotep(Peace)[9]!*
*—Selena T. Antá Rodgers/Poet DVA (2004)*

### *What is* The Art of Healing?

The *Art of Healing* addresses African-American families who desire to remain together while receiving assistance related to partner violence. *The Art of Healing* is an Afrocentric helping guide for practitioners. It is an

Afrocentric, strength-based training program and interdisciplinary Rites of Passage intervention tool that should be used with other African-centered, workbooks and support group models. The *Art of Healing* introduces culturally specific themes and ideas for practitioners working with African-American families to reaffirm and restore African heritage and culture. "No single policy or program will eliminate intimate partner violence" (Hampton et al., 2003, p. 552). *The Art of Healing* is proposed for what might work. It has not been empirically evaluated.

As with other groups, African Americans vary in their interests, values and behaviors. There will be issues of model appropriateness that should be assessed on an individual basis (e.g., acute mental illness, substance dependence, high lethality cases). Therefore, to determine who is appropriate, practitioners should pre-screen the family using safety instruments (see Tables 4 & 5). Further *Umoja Wellness Teams* should include: the family, the mental health system, the child welfare system, the criminal justice system, and other systems, (e.g., spiritual networks, school system, etc.) *Umoja Wellness Leaders* (families who have successfully moved from violence to nonviolence are encouraged to meet and partner with current families) should be involved with each family participating in *The Art of Healing* Rites of Passage.

## *The Goals of* The Art of Healing

The goals of *The Art of Healing* are: 1) reduce risk of partner violence and increase safety through a collective response of the family, community, and systems; 2) begin the healing process caused by *separate but treatable* responses to Africans Americans who experience intimate partner violence; 3) educate and provide a helping guide to practitioners working with African-American families who experience partner violence; and 4) provide culturally specific resources.

## *The Objectives of* The Art of Healing

The objectives of *The Art of Healing* are: 1) To assist families to transition from violence to nonviolence; 2) to work with the "family" and multisystems in which they may interact; 3) to promote African heritage and pride within African-American families, community, and culture (see Table 6).

## *First Steps in Using* The Art of Healing

Practitioners can use any combination of the Nguzo Saba that is viewed as important in working with families. Copies of the material mentioned below are available by emailing the author at nubianONEness@aol.com. To use the Art of Healing requires that the following plan be implemented:

**Table 4. The Art of Healing—Violence Threshold Assessment (VTA). (Sample)**

(VTA should be conducted during the beginning of every session)
(Please document responses of family members in their own words)

Family member providing data: Bintou Sanfoka (mother)

Name/title of person Completing VTA: Dorothy L. McNeil, Social Worker
Date: August 10, 2004

On a scale of 1–5 (5 = extreme risk of safety) what number would you use to describe violence threshold today? 3

Please explain incident:
Mrs. Sanfoka reports that she and her husband had a fight regarding Mr. Sanfoka's excessive alcohol consumption. "I slapped him in the face and he pushed me against the wall" stated Mrs. Sanfoka.

Do you still feel safe to return home to your situation?
Yes, we just need to figure out how to communicate.

When would you know that a situation was escalating to dangerous e.g., yelling, hitting, swearing, kicking, other (please explain)?
I think it would be dangerous if either one of us used a weapon, like a knife, but that has never happened.

Will you ever be able to assign your situation a VTA number 0?
Some day, but not right now.

What would be different?

For you: I won't yell as much.
For intimate partner: He won't drink as much.
For child(ren): My daughter will bring home better grades and my son won't yell as much.
For others: Yetunde, my spiritual mother, will visit our home again.

(This is an opportunity for the practitioner to discuss, role play, reframe, model positive behavior of communication with family members.)

How might wellness team members support you and your family through this incident? (what will be helpful if future incidents arise?)

I would feel comfortable calling my Umoja Wellness team members and/or leaders if I felt they could really understand what we are going through and could give us really good advice and support.

1. **Build it, bridge it, bind it.** Services should be guided by target population core beliefs. Language of literature should be cultural-specific. Establish relationships in the community. Recruit participants from various systems for the purpose of working collaboratively to restore families and/or build future healthy relationships (see Table 7).
2. **Conversations for consciousness.** Incorporate discussions of "isms" as part of training sessions. Be aware and discuss "triggers" that might

**Table 5. The Art of Healing—Family Safety Plan.**

- *Collaborative contracting.* Each family member, as well as *Umoja Wellness Teams* (e.g. representatives from spiritual networks and "systems" — mental health, criminal justice, child welfare, school, etc.) must be willing to sign family safety plan.
- *Complete family safety plan.* Does safety plan include spiritual outcomes to aide families' movement through partner violence? Are meetings with Umoja Wellness Teams being held? Does safety planning bring systems together, e.g., police, courts, child welfare system, schools, cultural institutions, spiritual networks and service providers?
- *Encourage families to rename violence through their lens.* Violence means something different for every family seeking services. How does each family communicate violence? What does safety mean for families?
- *Explore anger.* How has/does oppression (e.g., poverty, lack of education, lack of employment, lack of affordable housing, lack of adequate childcare) impact your role in your family and society? What does it mean to be African-American?
- *Family ties that bind.* Explore family of origins and family networks (kin and nonkin). Use the family tree as a source of data collection. Explore the roles of family members, pre- and postpartner violence. Identify positive and negative multigenerational responses to intimate partner violence.
- *Set milestones.* When possible, explore option of restoring and/or creating alternative healthy family units (e.g., preventing cycles of violence in future relationships).

  Violence → Reframe violence → Effective communication → Nonviolence

- *Violence threshold.* When should family "business" be considered partner violence? When would you know that a situation is escalating to dangerous e.g., yelling, hitting, swearing, kicking, other (please explain)? Check-in with family members at beginning of session to determine threshold of violence, e.g., on a scale of 1–5 (5 = extreme risk of harm) what number would you use to describe the violence threshold today? Discuss, role play, reframe, model positive behavior, respect, etc. Violence Threshold Assessment (VTA) should be conducted during the beginning of every session. This also allows practitioners to assess the extent of openness or rigidness of the family.

influence ability to work with others who do not hold similar beliefs. This can be addressed by identifying various speakers from the community to offer workshops on common ethnic triggers that surface when working with African-American families.

3. **Heritage negotiator.** Assist practitioner to identify and balance personal and professional competing beliefs and values. For example, a person may feel pride about some aspects of his or her spiritual beliefs, and conflict about others, or there may be an immobilizing "tug-of-war" between personal aspirations, family, and racial loyalty (see Table 8).
4. **Each one teach one.** Community networks should be used as a strategy to develop and deliver training needs that reflect the experiences

**Table 6. The Art of Healing—Umoja Wellness Goals.**

☥ *Circles of support.* This process is important for families and Umoja Wellness Teams to have a series of structured meeting times to address every person's role in responding to violence.
Goal: Prevent cycles of violence in future relationships. Reduce "isolation" by assisting women and families move beyond the tug-of-war of keeping "secrets" and receiving assistance for partner violence that hinder families from remaining intact.

☥ *Spirituality and wellness.* Identify what spirituality means from families' perspective. When appropriate, begin and end sessions with nondenominational prayer/meditation, or simply set goals around family values and beliefs; emphasize strength-based responses.
Goal: Interconnectedness and spirituality are used as coping responses necessary to decrease partner violence.

☥ *Interdisciplinary rites of passage model.* Use Afrocentric principles to integrate Nguzo Saba as a code of cultural ethics to accomplish positive outcomes of social justice, human dignity and self, family, and community worth.
Goal: Increase hopefulness that partner violence can transform from violence into nonviolence (It is important for families to write down their experiences as well as what their lives would look like if there was no more violence).

☥ *Pass the torch mentoring program.* Train Umoja Wellness Teams around the country to use *The Art of Healing* with families who experience partner violence.
Goal: Intimate partner violence will no longer be a public health issue. Teach communication, pride, love, responsibility, etc.

☥ *Violence reconstructed.* Develop collaborative networks between "systems" and African Americans. Each person in the family system as well as members from other systems must sign a contract agreeing to participate in The Art of Healing Rites of Passage Program.
Goal: Establish positive rapport; increase levels of trust and respect will result in improved responses by "systems" to partner violence as well as African-American families' willingness to access these systems.

☥ *Links and lineage.* Implement a range of culturally specific treatment and intervention models, (e.g., *Growing up Black* and *Proud, The Kinship Journey, The Art of Healing, The African-American Activity Book for African-American Families: Helping Children Cope with Crisis).* Integrate activities that include interactions between inter/intragenerational.
Goal: Assist practitioners and families to work through violence, while simultaneously celebrating African heritage.

☥ *We-ness wellness meetings.* Use retreats as an opportunity to engage families, systems and Umoja Wellness Teams. This is an opportunity for reciprocal and continuous feedback.
Goal: Restore trust, justice, and unified response to partner violence.

of families being served and should include participation from outside agencies.

5. **Embrace newness.** View discussions as an opportunity to provide a collective platform for addressing partner violence.
6. **Hands up, not hand outs.** Look beyond traditional funding sources to provide pro bono training for families on developing business plan,

**Table 7. The Art of Healing.**

**An Interdisciplinary Rites of Passage for Addressing Intimate Partner Violence**

☥*Umoja (Unity) Session one—Session three*

- Recruit Umoja Wellness Teams.
- Orient families, community members, and service providers.
- Identify interdisciplinary Umoja Wellness Team Leaders and members' responsibilities.
- Conduct prescreening to assess appropriateness for The Art of Healing Rites of Passage (use family safety assessment tool and prequestionnaire.
- Review confidentiality and discuss instances whereby a case would be reportable to State Central Registrar (SCR) with the understanding that the goal is to maintain the family unit in a violence-free environment. Sign confidentiality wavier between family members and other participants.

☥*Kujichagulia (Self-determination) Session four—Session seven*

- Develop with families a sense of self within the family-self, and the community-self, racial-self.
- Explore every family member's role. Discussion items require time commitments (each family member should keep a family journal to document activities and experiences.

☥*Ujima (Collective Work and Responsibility) Session eight—Session eleven*

- Incorporate themes of solution-focused vs. problem-focused outcomes to conflict.
- Communicate and establish hopefulness vs. helplessness, respect vs. disrespect, empowerment vs. power/control, etc. (Use of role-play activities should be incorporated).

☥*Ujamma (Cooperative Economics) Session twelve—Session fifteen*

- Conduct workshops to teach money management.
- Assist with résumé and/or business plan development, teach concrete occupational skills, and/or how to maintain job stability and career advancement.

☥*Nia (Purpose) Session sixteen—Session nineteen*

- Families should shadow identified Umoja Wellness Leaders (families that have successfully moved from violence to no-violence); meet and partner with current families (discuss and explore solutions to "systems." How have these systems aided and/or hindered their process of transitioning to no-violence in their families?)

☥*Kuumba (Creativity) Session twenty—session twenty-three.*

- Teach nonviolence through activities that highlight African-Americans' family experience with partner violence. e.g., collages, dance, documentaries, fashion shows, journaling, murals, paintings, plays, poetry forums, stage, view film or read, Ntozake Shange *'For Colored Girls Who Have Considered Suicide When the Rainbow is Enuf* (domestic violence experiences of African-American-related experiences), *Straight out of Brooklyn* film, *Sankofa* film *"Reach back and examine your past so that you may insure your future", Yesterday I Cried* (Iyanla Vanzant).
- Discuss the Willie Lynch Speech and issues of Posttraumatic Slave Syndrome; use these examples to discuss, dispel and assist African-American families with the healing process of partner violence.

☥*Imani (Faith) Session twenty-four—Session twenty-seven*

- Explore how spirituality can assist with partner violence.
- Introduce meetings between family members and spiritual networks that provide discussions of spiritual values, e.g., responsibility for one's actions, fulfillment and satisfaction, self-discipline, forgiveness, and a sense of purpose, etc.
- Transitional Ceremony—Postsurvey of partner violence and program evaluation.

**Table 8. The Art of Healing—Helping Guidelines for Practitioners.**

One need not be limited to the following rituals, but it is important to set the environmental tone to reflect and support cultural pride, including:

- Greet families each meeting by saying "*Habari Gani*" (*hah-BAH-ree-GAH-nee*), which means "What's new?" The response should be whatever principle the family wishes to focus on that session. Another example, might be to begin with a nondenominational prayer, meditation, and/or reading of an affirmation (proverbs and quotations from someone in the African Diaspora (e.g., Iyanla Vanzant, Maya Angelou). This is an opportunity to restore positive perceptions of self, family, and to develop positive responses to partner violence.
- Given the salient role of black forms of spiritual expression, it is important to include rituals of the African Diaspora. Practice rituals that may include: African dance, and other forms cultural expression. Another example might include lighting of candles (*mishumaa*), pronounced (*Mee-shoo-maah*) as a reinforcement of the Seven Principles. For example, at the beginning of each session families can perform rituals of lighting a candle, focusing on the selected principle toward the healing process to address intimate partner violence. Make "breaking of bread" a part of the meeting process. Food should differ to include various eating habits and traditions.
- Meeting place should reflect some Afrocentric ambience, e.g., pictures that reflect positive images of black families. Meeting places should include a combination of office, home, and community forums (academic institutions for larger activities).
- Sessions should end the same way they began, using Afrocentric proverbs, affirmations, and activities that reaffirm African Heritage and positive images of families without violence.
- Sufficient time should be allocated to incorporate the rituals as well as address the presenting concern and address the way the client identifies and labels the partner violence.
- The *Voices of Violence Umoja Hopeline*, a 24-hour hopeline (an evolving idea) information, referrals and a link to on-call Umoja wellness team (combination of professional and social support networks) will also meet with families in-person to work through presenting concern(s)/crisis.
- Umoja Wellness goals and outcomes for each session should be contracted on the seven communitarian values perspective. It is important to achieve Umoja Wellness goals through a combination of individual, family, and group sessions.

learning skills that will aid families become independent of "systems" (e.g., starting a home-based catering business). Send wish list to businesses requesting funding to purchase items, e.g. awareness ribbons, etc. In exchange, identified Umoja Wellness Teams (family and identified participants from systems) can contract to volunteer time to complete a project at sponsoring establishment. Explore fund-raising opportunities within for-profit institutions that have an investment in African-American families, e.g. academic institutions, athletic sponsors, music industry, private donors, special interest groups, etc.

7. **Shatter the glass ceiling.** Agencies that serve predominately African-American families must diversify managerial structures to include

culturally competent representatives of African-American communities. This will ensure inclusive "Afrocentric ways of knowing" during all levels of the decision-making process in defining and developing treatment and interventions for African-American families who experience partner violence. Also, work groups and policies should be established to address demoralizing experiences of African-American practitioners working within "helping" systems.

## Notes

1. see, Horton & Horton (2005) for detailed history.
2. See Appiah and Gates (1999), Africana: The concise desk reference. Running Press: 632.
3. Ibid, 208–210.
4. Ibid, 478–480.
5. Ibid, 755.
6. Abner Louima Torture Case, in 1997, Haitian Immigrant was beaten and brutalized by cops from the 70th precinct station, New York City. Accused officers stuck the handle of a plunger in Abner Louima's rectum and then forced the same object into his mouth, breaking his teeth. Louima was hospitalized suffering from a torn intestine, lacerated bladder, and other serious injuries. Source from: English and Spanish on Revolutionary Worker Online http://rwor.org.
7. As a result of 12 years of quantitative and qualitative research, Dr. Joy DeGruy-Leary has developed her theory of Posttraumatic Slave Syndrome, a theory that explains the etiology of many of the adaptive survival behaviors in African-American Communities throughout the United States and the Diaspora. Source from: http://www.posttraumaticslavesyndrome.com
8. This is the perceived benefit of coping with a life crisis or severe stressor event. Source from: Tedeschi and Calhoun, 1995.
9. Peace, calm, tranquility; offerings. Source from: Queen Afua (2000). Scared Women: A guide to healing the feminine body, mind, and spirit. New York: One World Ballantine Books.

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Chapter 7

# Get Thee Behind Me: African-American Grandparents Raising Grandchildren Who Experienced Domestic Violence

Karen Bullock

Domestic violence is a national health epidemic that occurs in every community and puts children at risk of being direct victims. African-American families are disproportionately represented among grandparent-headed households, many as a result of domestic violence. This chapter 1) examines the impact of domestic violence on grandparents raising grandchildren; 2) offers guidelines for assessing the impact of domestic violence; and 3) discusses recommendations for treatment and prevention.

The phenomenon of grandparents raising grandchildren is an increasingly common occurrence. Data from the US Bureau of the Census (2002) report that grandparents have the primary responsibility for the care of more than 1.3 million children in our country. Of the children living in grandparent-maintained households, the highest percentage (12%) is within African-American families; Latinos are about 6% and whites are around 4% (Bryson, 2001). Growth in African-American grandparent-maintained homes has been calculated to be as high as 20–50% in some poor communities. Moreover, a National Health Interview Survey found African-American grandparent-headed households to include an over-representation of poor, unemployed, and poorly educated individuals (Marx & Solomon, 1993). The domestic violence literature that has focused on the welfare of children suggests that families who live in poor, underserved communities with few resources to meet their basic needs are at risk for exposure to violence (Edleson, 1999; Hampton, 1994; Laudan,

1997; Lehmann, 2000; Oliver, 2000; Schechter & Ganley, 1994; Worrall, 2001). African Americans are over represented in the statistics on domestic violence (Blake & Darling, 1994; Gelles & Cornell, 1990; Hampton, 1994). This social trend justifies the need to focus specifically on this population.

## Background on Violence among African Americans

Domestic violence is not only a social problem, but also a criminal problem (Danis, 2004) that consists of behaviors that include repeated physical, sexual, and emotional abuse used to control an individual (Barbee, 2004; Campbell et al., 2002). Use of physical violence is the extreme manifestation of one person controlling another and is usually accompanied by behaviors such as threats and intimidation, humiliation, social isolation, and limiting resources. Sustained, high levels of tension and fear, as a result of sporadic and unpredictable violence, characterize violent home environments.

Although safety and the fear of violence have not always been viewed as areas of health protection, violence among family members is considered today a pervasive health concern (Greene et al., 1989). The family is critical to the development of values and protection of its members. The health and functioning of children and adolescents are influenced by the values and examples set by parents and other caregivers within the family. Behavior adopted in childhood influence health and social behaviors later in life. The process of protecting members from threats to their health and social well-being should be understood from a cultural variant perspective (Bullock et al., 2003).

African Americans are particularly vulnerable to these threats due to the effects of racism and poverty (Marsh, 1993). The poor are at greater risk of family violence than those who have an abundance of resources. As a group, African Americans are disproportionately poorer than whites (US Bureau of the Census, 2000). However, any individual who is not connected to a healthy nurturing support system is at risk for displaying maladaptive responses to stress and adversity. The day-to-day activities of trying to make ends meet can lead to hostility and aggression. Overcrowding and poor-quality housing also can influence violent behavior (Bashir, 2002). When individuals live in violent environments, social conditioning toward further violence may serve as a protective mechanism. In a study conducted with African Americans in hospital emergency rooms who were victims of violence (Rich & Stone, 1996), young men reported that either an unwillingness to use violence or the perception of "weakness" and vulnerability could result in more danger and increase the potential for violent abuse. Often times, people who are exposed to violence on a regular basis take on the values that surround them and most people in the environment operate on the same set of cognitive and behavioral imperatives. For some

violence is viewed as a rule for living and/or survival. The attributions of violence are then generalized to other contexts, such as family or intimate relationships (Williams, 1993).

Family protection strategies may be different according to cultural beliefs and attitudes. Protective behaviors such as strict parenting or corporal punishment, often seen in low-income family systems, may be mistakenly credited to race or cultural background, when actually, these parenting techniques may reflect differences in coping skills or the lack thereof. The tensions associated with social oppression may foster conditions that put African-American children at greater risk for exposure to violence. Despite the fact that African Americans are more likely than their white counterparts to be incarcerated for violent crimes (Williams, 1993) and the largest number of children being raised by someone other than their parents is among African-American children, the subject of domestic violence and grandparents raising children have been virtually ignored in the family studies literature.

Few theories are specific regarding domestic violence and the guardian role that grandparents assume in response to it. In fact, this family dynamic typically has not been discussed in the literature on domestic violence. Among the explanation of maladaptive behaviors in African-American communities, two theories stand out: structural theory and interactional theory. In these theories, scholars considered the experiences of African Americans either in oppressive or violent social environments. They report that an oppressive social environment encourages violence (Asante, 1981; Williams, 1993). Violent social environments uniquely affect many African Americans. Homicide is the leading cause of death among African-American men ages 15 to 35. They also have high rates of acquaintance violence and suicide. African Americans are more at risk for physical harm by other African Americans than by whites (Blake & Darling, 1994; Hampton, 1991).

Staples (1999) and Wilson (1991) suggest that violence in the lives of African Americans is allowed and even promoted because historically their lives have been devalued in American society (Hawkins, 1987). One consequence of an oppressive societal context is stressful and violent community environments that foster violent interactions within African-American families. Parents of adult children who commit acts of violence know that oppression among African Americans is a reality and regardless of culture, perpetrators are responsible for their abusive behavior. So often, individuals who experience violence endure these hostile, violent relationships to support their partner or family member in order to keep the family together (Asbury, 1989). Furthermore, children are more likely to experience maltreatment when they live with parents who are involved in violent relationships and do not have adequate coping skills and other resources to meet their basic needs (Edleson, 1999).

Exchange theory provides a framework to understand the challenges African-American grandparents face when dealing with domestic violence

and the factors that influence their decision to assume parental responsibility of their grandchildren. This perspective weighs the importance of reinforcement patterns, social rewards, costs and benefits in the decision making process (Nye, 1979). African Americans have a legacy of reinforcement of cultural norms and of providing for their family members through natural supports. Supportive family exchange networks exist when there are social rewards such as belonging, self-worth, dignity, and validation of family traditions. On the other hand, costly family arrangements are less likely to be sustained (Cook, 1978; Nye, 1979). This paradigm is useful in framing the discussion of grandparents raising grandchildren and the impact of domestic violence. An assumption in this framework is that individuals continue to be involved in the relationship as long as the benefits exceed the costs (Hendricks, 1995).

The cultural variant framework offers an explanation for the capacity of these grandparents to adapt to the demands of raising grandchildren even though the challenge may be great. A cultural explanation suggests that African Americans have been socialized with attitudes that encourage a strong value of extended family care. Furthermore, grandmothers are often viewed as the pillars of their families and communities as they represent strength and resiliency (Gibson, 2002; Kivett, 1993). Without a cultural dimension to the understanding of African-American family functioning, we are at risk of misinterpreting the responses and behaviors of those we seek to assist. The combination of these theories offers a model for understanding the complexity of African-American family functioning as a distinct cultural form.

## Grandparents as Parents

Traditionally, African-American grandparents have cared for grandchildren as a extended family responsibility (Carlton-LaNey, 2001). Grandparents stepped in to help parents due to employment demands, the lack of available day care services, or the lack of financial resources (Martin & Martin, 1995). These family relationships were often characterized by intergenerational reciprocity. Parents of the grandchildren contributed to the growth and development of their children in positive ways, and informal networks of support provided a buffer against stressors frequently associated with the challenges of trying to make ends meet with few resources (Dressel & Barnhill, 1994; Taylor, 1985). We find that factors such as abandonment, incarceration, substance abuse and domestic violence influence the transition that grandparents make in their role from grandparent to parent (Caliandro & Hughes, 1998; Poindexter & Linsk, 1999). This change in late life parenting responsibility may result in psychological, physical, and economic costs for older adults (Burton, 1992).

Although grandparents have always played important roles in caring for their children and grandchildren, we are witnessing in the United

States an unanticipated change in the role of the elderly. Grandparents are now questioning their ability to provide for their grandchildren in these difficult social times (Bullock, 2001). The rapid growth in the number of grandparents who are raising grandchildren has not occurred in a vacuum. Increasingly, social and economic conditions of African-American families are leaving large numbers of grandparents to manage children who have been negatively affected by the absence of their parents (Minkler et al., 1994; Fuller-Thomson & Minkler, 2000).

Contextual conditions, such as household composition and health status, can affect the grandparents' ability to care for the grandchild. African Americans have tended to live in extended family households (Carlton-LaNey, 2001) and the likelihood of having their basic needs met has been contingent upon the availability of informal family supports (Bullock, 2004). Because a large number of African Americans are poor, this puts grandparents at even greater risk for having to confront issues of domestic violence in the life of the grandchild they care for. The relationship between ethnicity and poverty has been well documented (US Bureau of the Census, 2000; 2002).

The involvement of grandparents in caring for children whose parents are unavailable to provide care is significant because the grandparents are often consistent providers of care and support (Gibson, 2002; Kivett, 1993). Grandparents fulfill supportive, childrearing functions. The ease with which grandmothers in particular, assume mothering roles for grandchildren may disguise the acceptability of the role. The historical portrayal of black grandmothers as guardians of generations, reflecting wisdom, leadership, and strength (Carlton-LaNey, 2001) is challenged when the family is confronted with domestic violence.

## Grandchildren Exposed to Violence

Children may be placed in the care of their grandparents for a variety of reasons including homicide (Kelley et al., 1997), substance abuse (Burton, 1992), abandonment, neglect, (Jendrek, 1994) and incarceration of parents (Dressel & Barnhill, 1994). However, many of these children experience violence that has not been adequately addressed among practitioners, policy makers, or researchers.

African-American children are at risk for exposure to domestic violence based on a report by Hampton and Gelles (1994) that black women, when compared to whites, were more than twice as likely to experience severe violence and that in families with incomes greater than $10,000, wife battering was twice as common among blacks as among whites. Laudan (1997) investigated the relationship between child maltreatment and domestic violence. More than 6,000 American families were surveyed on this topic. From the families that participated, researchers reported that men who abuse their spouses or partners also abused their children. The study

revealed that when women were abused the children in the home were as likely to experience abuse.

Over the past 20 years, incidences of child abuse and neglect have increased. Among African-American children, there has been approximately a 40% increase in reported cases as compared to 20% for white children. This amounts to nearly 500,000 African-American child abuse and neglect cases being reported annually (Hughley, 2000).

Baronet et al. (1997) examined the effects of martial violence on children. A survey was administered to document the relationship between child exposure to violence and health issues. They concluded that children who were exposed to this type of violence tended to exhibit more behavior problems than other children. The children who are exposed to violence are at risk for behavioral and emotional problems that may require mental health services. They are more likely to exhibit violent behaviors themselves when parents have modeled such behavior for them (Hampton, 1994). Because African-American children tend to be disproportionately represented in grandparent-headed households, in poor and resource-deprived environments, one might expect to find more literature available on how to intervene with these families. Yet, little is known.

One reason for the avoidance of discussing family violence across helping disciplines has to do with the prevailing ideology of the family as a unit characterized by affection and cooperation between its members. Yet research has shown that many grandparents who raise grandchildren receive no consistent family support (Burton, 1992; Fuller-Thomson & Minkler, 2000; Gibson, 2002; Solomon & Marx, 1995; Whitley et al., 2001). Domestic violence impacts these families in ways that put them at greater risk for physical and mental health problems. Although grandparents are viewed as a strong source of authority and vital resource that keeps African-American families intact, there may be areas in which these family networks can be supported to provide more optimal care.

## Examining the Impact

A research study by the author of this chapter was undertaken to examine the impact of grandparents raising grandchildren. The sampling for this research study involved several steps. First, four towns in the southeastern region of North Carolina were selected to provide the initial introduction of the study to families with children. A community family and children services agency was identified for collaboration where practitioners provided names of potential participants. Then, a sample of convenience was developed through community recruitment efforts and word of mouth. Informational flyers were posted throughout the community, including schools, churches, and community service agencies. In the first round of

interviews, only grandmothers responded to the recruitment efforts. Upon learning that almost 40% the participants were married and living with a spouse, researchers conducted a second-phase study, which targeted grandfathers. A snowball sampling technique (Delgado & Tennstedt, 1997) was utilized to increase the likelihood of finding other grandfathers who were caring for grandchildren. To achieve a matched sample of males with females of the larger study (Bullock, 2001), participants met the following criteria:

- age 65 years or older;
- responsible for the care of at least one grandchild aged 18 years or younger;
- live in one of the four identified county areas;
- able to understand and speak English.

The study's purpose and procedures were explained to each potential participant. Research participation was voluntary and informed consent was required. Thirty men and 61 women, aged 65 years and above, who were responsible for the care of at least one grandchild agreed to participate. Overall, 65% of the grandparents were either African-American men (30%) or women (70%). Those grandparents provided the data presented in this chapter.

## Gathering the Facts

Given the exploratory nature of the research, a semistructured qualitative approach was used to gather data. In-depth open-ended interviews were the primary source of information (Strauss & Corbin, 1990). Questions about circumstances and contextual elements that lead to the child being raised by the grandparent were included in a semistructured questionnaire. Participants were also asked to discuss changes that had occurred in their lives as a result of their parenting responsibilities. These steps in the process are common in "ethnographic methods and analytic techniques . . . as a means of constructing an accurate and insightful understanding" (Gubrium & Sankar, 1991, p. 10).

Interviews were conducted in the respondent's home or a community setting (as preferred by the respondent for comfort and convenience). Each interview lasted about 60 minutes and was tape-recorded for accuracy of data. Questions were framed as intervention questions and used to elicit family explanations of cause and effect, but most importantly to explore relationships between family members, events, beliefs, and behaviors. The use of intervention questions can be helpful to practitioners who work with families to identify the risks and behavior changes that support family caregivers (Wright & Leahy, 2000). This collection methodology made it possible to capture the viewpoints of grandparents who are often not the

focus of research and knowledge building. Most of these grandparents were recruited through churches and community-based agencies.

## Analyzing the Facts

Line-by-line coding of the transcripts was accomplished first independently and then in joint session by the principal investigator and two trained research assistants. As recommended by qualitative research experts (Miles & Huberman, 1994; Mays & Pope, 2000), several methods to enhance the validity and reliability of the findings were employed. A consistent interview guide was used, audiotaped interviews, and the transcribing of tapes occurred within 8 hours of the interviews using independent transcribers. The code structure was expanded and refined iteratively as additional transcripts were reviewed. With each additional transcript coded, recurrent themes were noted, and quotations were grouped within these themes using the constant comparative method (Glaser & Strauss, 1967; Patton, 2002), until the point of theoretical saturation, or no new themes emerged. As a final step, all transcripts were reviewed to detect any discrepancies in codes and negotiated until consensus was reached. The software QSR NUD-IST 4.0 (Sage Publication Software, Thousand Oaks, California) was used to assist in the coding process, to identify textual illustrations of recurrent themes, and to make comparisons between the themes described by the grandparents.

## Who?

Of the 59 African-American grandparents that participated in the study, 41 identified violence as a factor in their assuming the role of parent for their grandchild or grandchildren. Most of these families were living on a low, fixed income of less than $1,000 monthly. The mean age was 70 years and a majority had less than 8th grade education. The number of grandchildren cared for by these grandparents ranged from 1 to 7, with more caring for a single grandchild.

## What are the Target Areas for Prevention and Treatment?

Intervention questions were utilized to determine target areas for African Americans. The elderly grandparents who participated in this study identified factors that they felt contributed to the violence that their grandchildren were exposed to, which in their opinions, resulted in the children being placed in the home of the grandparents. The most commonly

identified were socialization, marital or relationship conflict, having too many children, substance abuse, and a lack of parenting skills and financial resources.

These grandparents seemed to have quite a bit in common in terms of their social, cultural, and economic experiences. All of the grandparents felt that their desire to protect the grandchild from harm was a deciding factor in their assuming parental responsibility for the child. They felt the children lived in chaos prior to leaving or being removed from the parents' care. From this feedback, certain recommendation can be made for intervening with African-American grandparents raising grandchildren who have been exposed to domestic violence. The meaning that grandparents assign to the event influences how the family responds to the stressors. Moreover, this appraisal influences the strategies the family uses to cope and adapt to the stressor (Boss, 2002).

A distinction of grandparents raising grandchildren who were exposed to domestic violence is their fear of the child who exhibits violent or aggressive behaviors. Several grandparents expressed concern about the rage that their grandchildren displayed and their grandparents' inability to calm the grandchild or manage his or her behaviors. These grandparents reported that they wanted to protect their grandchildren from violence and not foster it in the family environment. However, there was tension between their beliefs and practices about disciplining children, which they labeled as cultural norms, and these desires.

## Families in Need

The grandparents all seemed to have great concern for their families and therefore, had accepted the parenting responsibilities as a protective mechanism for the grandchildren. Not all of them view the grandchildren they are raising as having been seriously impacted by domestic violence. They were, however, able to identify specific needs of the children.

Access to health care services was one identified need. Health care is essential for family protection and preservation. The family's ability to meet the needs of its members hinges on early detection of risk so that appropriate prevention strategies can be implemented. Many families place high priority on areas for which the threat of harm or illness is apparent and easily understood. Helping grandparents to understanding the impact of domestic violence on children and families is critical, but it does not assure access to services. Additionally, these families were in need of financial resources, support with activities of daily parenting, adequate housing, and educational resources.

These areas of need are consistent with those that have been emphasized as contributing to domestic violence. Family health protection can be

supported through the treatment and prevention services. However, services must be affordable, accessible, and culturally acceptable for African Americans.

## Guidelines for the Assessing Working with Grandparents Raising Grandchildren

The information that these grandparents provided has implications for domestic violence treatment and prevention practitioners. The role of the practitioner in intervening with these families will vary according to the needs of the family. When a grandparent accepts the role of parent for a grandchild as the result of family violence, the practitioner is advised to begin with an assessment of the family's basic needs. Assess the family members' health, housing, food, clothes, and safety. It is difficult for individuals to focus on behavioral changes if they are hungry, homeless, or unhealthy.

The next step is to assess the family values and beliefs about domestic violence and help-seeking. This includes parenting beliefs and practices, especially as they relate to corporal punishment. Family history of violence and the level of tolerance and exposure to violence are important factors to consider. Assessment of family social and protective behaviors involves a collection of data from which family strengths, concerns, and actual or potential problems can be identified. A thorough assessment of adaptive social values and norms using a genogram (Bullock, 2004) is one way to assess and teach families about interpersonal dynamics and their impact on family functioning. Davis (1991) postulates that the only way to effectively eradicate the problems of family violence among African Americans is to change social perceptions about its basic nature.

Many of the factors that are protective to African Americans need to be viewed through a cultural lens in order to understand the origin and perception of those behaviors. Grandparents in the study discussed earlier acknowledged their use of and support for spanking children and yelling. Grandparents reported using these approaches because they are effective in achieving compliance and are culturally accepted. Several grandparents made a religious reference to "spare the rod and spoil the child" as having strong cultural influence on African-American parenting beliefs and practices. However, according to Gershoff (2002), children reared in homes where spanking is used have more delinquent behavior, are more aggressive, have poorer mental health, and have poorer parent-child relationships. A continuation of the culturally accepted parenting style may be more troublesome for grandparents than helpful. A health-risk appraisal is useful for assessing individual and family risk factors, and it provides families with a realistic estimate of the major hazards to which they are

vulnerable. Family members may be more amenable to recommended lifestyle changes if they are shown specific risk factors and understand their risk.

Practitioners should consider themselves as partners with the families they seek to assist. Therefore, the steps in treatment and prevention involve both the practitioner and the family. The following is a guideline for planning and implementing intervention: 1) review the family assessment data and family health status; 2) identify and reinforce strengths of the family; 4) assess family values, attitudes, and beliefs about violence; 5) collaboratively identify behaviors and outcomes that will indicate success; 6) address social, environmental and interpersonal factors that are barriers to change; 7) determine the time frame for implementation; and 8) commit to the family's goals and the structure and support needed to accomplish them. Although the family is ultimately responsible for carrying out the collaborative plan, the practitioner plays an active role in encouraging the family's success.

## Treatment and Prevention

Some family factors are effective in preventing children's exposure to domestic violence. Family cohesiveness, social support (Schechter & Ganley, 1994), safe housing (Campbell et al., 2002), adequate financial resources, and high levels of parental monitoring mediate risk factors and positively influence decreased violent behavior (West, 1999). Evaluation is the ongoing process between the practitioner and the family that measures the progress that has been made toward goal achievement. An approach that builds on family strengths such as family capacity, competency, and resources is recommended when working with these families. The elaborated family strengths are then nurtured and supported by identifying and mobilizing resources. The practitioner can play a number of important roles in supporting families' protection and functioning (Feeley & Gottlieb, 2000).

In the role of mediator the practitioner should be aware of the dynamics between family members and their values and beliefs about family support. Although, family members are not always the best source of support when treating domestic violence, they may be the desired source of support. Caregiving can be rewarding to the grandparents in spite of the struggles they confront in their role as parents. They are protective of family members and are often reluctant to talk to formal providers about the details of the domestic violence. They wish to protect their adult children in addition to protecting the grandchildren. Although this balancing act creates stress for grandparents, they value family preservation and often try to manage the family conflicts without outside intervention.

The goal of the practitioner in preventing violence in the family is to improve communication and cooperation, while reducing anger,

hostility, and other potentially violent behaviors. This prevention approach is valuable when power struggles have escalated and the fundamental trust needed to sustain a healthy relationship has eroded. Effective mediation with grandparents and grandchildren is grounded in the ability to engage in active listening, a skill that requires each individual participating in the conflict resolution to be willing to set aside his or her own needs. In addition, participants are required to learn skills for effectively defusing emotional reactivity and the development of empathy.

Prevention of family violence can be facilitated by scheduled regular sessions for discussion. Weekly meetings provide a forum that offers families the time to discuss the concerns of each member, as well as to role-play family situations that could escalate to violence. This approach builds healthy communication and the development of skills for constructive problem solving. For this approach to be effective, the mediator must help family members identify issues of conflict and facilitate communication that leads to positive behavioral changes, while serving as a neutral, culturally competent third party.

## Conclusion

Practitioners can play a vital role in working with these families to identify risk and adopt strategies to prevent violence. Much remains to be learned about family protection practices. Research is needed in understanding African Americans' perception of violence and the impact it has on children who are being raised by grandparents. The atmosphere in the home created by the use of violence and threats of violence has been described as "social chaos" by the grandparents in the author's work and the rules governing behavior are constantly changing and being redefined. This leaves the family members uncertain about how to respond to the changing demands and aggressive behaviors of grandchildren who have been exposed to domestic violence. The role of the practitioner in treatment and prevention should be to support the family's risk identification, education, and positive behavioral change.

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Chapter 8

# A Practitioners' Guide to Evaluating Domestic Violence Prevention and Treatment Programs

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Across an array of health and human service fields, program evaluation has an important role in bridging the gap between science and practice (Morrissey et al., 1997; Vinh-Thomas et al., 2003; Wandersman et al., 1998), identifying promising and effective program models to address community needs (Vinh-Thomas et al., 2003), and sustaining initiatives (Weiss et al., 2002). Due to emergent community problems that often require innovative responses that rapidly evolve, advances in program development and implementation typically progress well beyond the evaluation of these efforts.

The purpose of this chapter is to first articulate a rationale that supports the growing momentum toward the development of well-formulated approaches to evaluation by highlighting how the systematic assessment of community-based programs can benefit the agencies conducting these programs and also make significant contributions to the evaluation field as a whole. Second, major components involved in conducting a program evaluation are outlined giving emphasis to a particular philosophy as well as the major steps that need to be addressed. Third, the evaluation of a particular community-based initiative to address the problem of family violence as a case study[1] is provided in order to provide practical program evaluation information to assist community-based organizations (CBOs) and professionals working with these organizations in the development

and implementation of evaluations that are doable, meaningful, and sustainable. It is our hope that the presentation of the rationale, major components, and case illustration of program evaluation will assist program directors and staff in meeting funders' growing requirements for monitoring performance and assessing program results. And finally, we conclude by providing lessons that we have learned in conducting community-based family violence program evaluations.

## Rationale for Program Evaluation

One strategy that funders have used to better ensure the success of programs carried out in communities is a requirement that grantees implement programs that research already has demonstrated to be effective; this is known as evidence-based programming (McCall et al., 2004). Several researchers have pointed out the limitations of this strategy and caution against using only this approach to community programming (McCall et al., 2004; Pentz, 2003; 2004). A major limitation is that little is known about the effectiveness of some of these programs when they are carried out in real-world settings and with populations or communities that differ from those for whom they were originally designed and researched (Roberts & Yeager, 2004). For example, few evidence-based programs have been developed for populations and communities of color (Vinh-Thomas et al., 2003), therefore, we do not know whether these programs are still as effective when adapted and carried out with these groups. McCall et al. (2004) pointed out that using an evidenced-based approach may not be possible because there is a paucity of evidence of what works for certain societal issues. An equally important issue in the movement toward evidence-based programming is that since community-based programs emerge out of real needs, they may be just as or more effective than those derived from science. Thus, an important rationale for conducting community-based program evaluation is that it provides communities with the opportunity to inform science, improve practice, and develop models of effective programming.

Program evaluation is also useful in the fight to sustain funding for social service programs because they are receiving scrutiny due to questions about their performance (Martin & Kettner, 1996). The ability to present evaluation findings and positive aspects of programs to stakeholders can help to secure support for institutionalizing programs (Jacobs, 2003; Mancini & Marek, 2004; Vihn-Thomas et al., 2003) and foster community development around a particular issue (Burt et al., 1997).

In addition to the reasons mentioned above, there are other reasons why we advocate assessing community-based programs. The first is stakeholder accountability. Rossi et al. (2004) define accountability as "the responsibility of program staff to provide evidence to stakeholders and sponsors that a program is effective and in conformity with its coverage, service,

legal, and fiscal requirements" (p. 200). Accountability is most commonly applied to the funder-fundee relationship, such that the funder wants to know if resources are expended wisely and if programs are effectively addressing the problems they were funded to target. Although anecdotal evidence of program effectiveness should not be discounted, funders are less frequently relying on this type of information as the sole evidence of program effectiveness. Instead, grantees are now required to collect and report on performance measures (Hernandez, 2000) and to include outcome evaluations in the assessment of program results (Wandersman et al., 2000). Funders can use these evaluation findings to make important decisions about where to direct scarce resources and to determine what their investments have yielded. The funder is an important stakeholder to whom family violence programs should demonstrate positive results. However, there is also a need for accountability at other levels, including to consumers and representatives of the larger communities in which these programs take place. Providing effective programs is a social responsibility.

## Key Elements of Program Evaluation

Program evaluation is defined as "the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development" (Patton, 1997, p. 23). The goal of program evaluation is to assess the design, implementation, and efficacy of social interventions for the purpose of improving social conditions (Rossi et al., 1999; Weiss, 1972). Over the last four decades program evaluation has rapidly developed and is a field that spans many disciplines, such as psychology, social work, education, and public health. Unfortunately, due to its growth and widespread application, there is inconsistency in the use of terms and concepts within the field. This inconsistency has resulted in confusion among practitioners and evaluators alike. To facilitate a common understanding for the purposes of this chapter and for beginning program evaluation work, Table 1 provides definitions of the most commonly used program evaluation terms.

### *Program Evaluation Philosophy and Conceptual Framework*

Our approach to evaluation is influenced by participatory (Cousins & Earl, 1992; Fawcett et al., 2003), utilization-focused (Patton, 1986), and empowerment evaluation (Fetterman et al., 1996) and places major emphasis on collaboration, building capacity at all levels of a program and the community-based organizations in which it is housed, and utilizing the continuous feedback of data for ongoing program and policy decision-making (Kaufman et al., in press; Tebes et al., 2000). The primary goal

**Table 1. Program Evaluation Terminology**

| Terminology | Description |
|---|---|
| Accountability | The responsibility of program staff to provide evidence to stakeholders and sponsors that a program is effective and in conformity with its coverage, service, legal, and fiscal requirements (Rossi et al., 2004, p. 2000). |
| Benchmark | The level of outcome attainment that you expect or hope for (W.K. Kellogg Foundation, 1998, p. 34). |
| Cost–benefit analysis | Determining whether a program's benefits outweigh the costs (Schalock, 1995, pp. 6, 14). |
| Comparison group | Individuals whose characteristics are similar to those of your program participants. These individuals may not receive any services, or they may receive a different set of services, activities, or products. In no instance do they receive the same services as those you are evaluating (the Administration on Children, Youth, and Families, The Program Manager's Guide to Evaluation, http://www.acf.hhs.gov/programs/core/pubs_reports/prog_mgr.html). |
| Control group | A group of people who qualify for your service, but when they apply are randomly assigned not to receive the service, so you can observe how they differ over time from those who do receive the service (Mattessich, 2003, p. 79). |
| Effectiveness | Extent to which program obtains its goals and objectives (Schalock, 1995, p. 14). |
| Program goal | A statement, usually general and abstract, of a desired state toward which a program is directed (Rossi et al., 2004, p. 99) |
| Indicator/measure | Measurable approximation of the outcomes that are attempting to be achieved (e.g., a score on an instrument that measures self-esteem is an indicator of self-esteem) (WK Kellogg Foundation, 1998, p. 33). |
| Impact evaluation | An evaluative study that answers questions about program outcomes and impact on the social conditions it is intended to ameliorate (Rossi et al., 2004, p. 63).<br>Determines whether the program made a difference compared to either no program or an alternative program (Schalock, 1995, p.13). |
| Mission statement | A statement that articulates clearly your purpose and desired outcomes (Schalock, 1995, p. 28). |
| Needs assessment | An evaluative study that answers questions about the social conditions a program is intended to address and the need for the program (Rossi et al., 2004, p. 64) |
| Program objective | Specific statements detailing the desired accomplishments of a program together with one or more measurable criteria for success (Rossi et al., 2004, p. 99) |
| Outcome | The changes that occur because of the efforts by an organization among the persons, groups, communities, or organizations affected by those changes (Mattessich, 2003, p. 15) |
| Outcome evaluation | Evaluation designed to ask the extent to which a program or intervention affects participants according to specific variables or data elements (Administration on Children, Youth, and Families, http://www.acf.hhs.gov/programs/core/pubs_reports/prog_mgr.html. |

(*continued*)

**Table 1.** *(Continued)*

| Terminology | Description |
|---|---|
| Outputs | Reflect internal activities; the amount of work done within the project or organization (Burt, Harrell, Newmark, Aron, & Jacobs, 1997, p. 66) |
| Process evaluation | A form of program monitoring designed to determine whether the program is delivered as intended to target recipients. Assesses the fidelity and effectiveness of a program's implementation (Rossi et al., 2004, pp. 64, 56) |
| Performance indicators | Measures that describe how well a program is meeting its objectives (USAID, 1996)— http://www.dec.org/ pdf_docs/ pnaby214.pdf. |
| Performance monitoring/ Program monitoring | Used to provide information on: 1) key aspects of how a system or project is operating; 2) whether, and to what extent, prespecified project objectives are being attained; and 3) identification of failures to produce project outputs; 4) monitor service quality by collecting data on the satisfaction of those served; 5) report on project efficiency, effectiveness, and productivity by assessing the relationship between resources used and the output and outcome indicators (Burt et al., 1997, p. 62). The systematic documentation of aspects of program performance that are indicative of whether the program is functioning as intended or according to some appropriate standard. Monitoring generally involves program performance related to program process, program outcomes, or both (Rossi et al., 2004, p. 64). |

is to build agencies' evaluation capacity by providing the skills and structures that enable programs to grow and sustain their effectiveness. In many ways, our approach to evaluation expands the purpose, roles and potential settings of evaluation beyond that of traditional evaluation approaches or those in which the evaluator may conduct the evaluation more independently. Thus, our approach is best suited for CBOs and programs that have desire and willingness to build their internal capacity for collecting data and utilizing it for continuous program improvement. We are mindful that program evaluation is anxiety provoking for community providers; it is not what they have been trained to do, they have few resources to do it, and, in general, they prefer to work with clients and not data. Given that we ask CBO staff to do things that they may not have the expertise or a strong desire to do, experience has taught us that the process of evaluation cannot be successful without the support of the program and agency leadership. Therefore, we believe that an essential task is to develop and maintain relationships at multiple levels of an agency, from the executive director to champion the process to the direct service staff that is responsible for carrying out the majority of the day-to-day service and evaluation tasks, to the nondirect service staff who will be responsible for management information system (MIS) interface. It is these relationships that provide the

foundation for an environment of program evaluation learning and enable us to perform our role and help to mainstream evaluation so that it is an integral part of programming (Wandersman, et al., 2003). The provision of evaluation training technical assistance is the most important aspect of mainstreaming and institutionalizing the evaluation processes and procedures, particularly in the first year of implementing an evaluation in a CBO. Therefore, our team provides training and technical assistance *very* frequently (i.e., as often as needed, which can be daily). As staff develops increased capacity, the frequency with which we provide training and technical assistance reduces. Training and technical assistance consists of open, ongoing communication with staff at all levels of the program and takes place via electronic mail, telephone, and/or face-to-face meetings. We conduct face-to-face training with all staff on evaluation processes (i.e., proper completion of data collection forms and administering outcome surveys). Finally, we place great emphasis on collecting reliable and valid data that can be used to help programs continuously improve their work and systems and to make sound decisions regarding resource allocation and policies.

Unfortunately, although funders mandate evaluation, they rarely provide the training and technical assistance to support it. Our work draws upon models of accountability in which there is a partnership among the funder, the funded program staff, and the evaluator. The partnership provides the foundation for the work, and each partner has roles and responsibilities for carrying out various aspects of the evaluation plan. In order to be successful, the funder provides the resources for evaluation, the programs, and the work of the evaluator *and* sets the tone, expectations, and value of evaluation. The funders' commitment and buy-in to the process helps to insure that the applicant (ultimately the funded program) understands the importance of evaluation and establishes their commitment to the process (Crusto & Wandersman, 2004; Wandersman et al., 2003; Yost & Wandersman, 1998). It is with this philosophy that we carry out the evaluation processes and activities presented below. Each evaluation step is described and provides general issues and cultural competence issues that should be considered by program staff and evaluators.

## *Steps to Conducting a Program Evaluation*

**Step 1: Developing a Theory of Change and Logic Model.** The first step is to work with staff to develop the program's theory of change or, in other words, how they see that the program will "work" to influence the desired outcomes (WK Kellogg Foundation, 2000; Weiss, 1995). We collaborate with programs to create a logic model that is a "systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan to do, and the changes or results you hope to achieve" (WK Kellogg

Foundation, 2000, p. 1). In order to create an accurate logic model, staff provides us with a detailed description of the program, from the mission, goals, and objectives to specific activities, deliverables, and outcomes. They describe the population they are serving, typical program operations, how consumers progress through the program, and other stakeholder and agencies in the community with whom they collaborate to implement the program. We ask for any data gathered about the program, including anecdotal impressions, so that we can build on what is already known about the program and what has already been done. The process of creating a logic model is just as important as the model itself, because it contributes to the development of consensus among program staff about the program components, improves and focuses the direction of a program (Centers for Disease Control and Prevention, 1999). We have experienced programs in which staff members differ in their understanding of program mission, goals, objectives, activities, deliverables, or outcomes. The logic modeling process makes all of these aspects of the program explicit and allows staff to evaluate how the available resources and program activities will achieve the desired results (see Appendix A for program evaluation resources, including logic model development resources).

*Issues to Consider When Developing a Logic Model*:

- Are the program goals and objectives realistic?
- Are the program activities consistent with the program goals and objectives?
- Are there sufficient resources to implement the activities with quality and fidelity (the way they are proscribed/supposed to be implemented)?
- Can the program realistically carry out the desired activities?
- Can the outputs (deliverables) realistically result from the activities?
- Do the activities and outputs have a realistic chance of influencing the desired outcomes (e.g., are the activities intensive and comprehensive enough, of sufficient duration, and targeted to the appropriate groups to realistically impact the desired outcomes)?

*Cultural Competence Considerations When Developing a Logic Model*:

- Has the program considered that identification of variations in risk factors by cultural groups is essential to effective prevention and intervention efforts?
- Programs that are based on inappropriate theories for the target group are unlikely to produce the desired outcomes; is the same theory of change espoused relevant for all racial or cultural groups that the program serves?

**Step 2: Developing the Evaluation Questions.** The prospect of conducting a systematic program assessment can be daunting for CBOs. Even shaping evaluation questions or articulating what they want to know about their program often challenges staff and may be a barrier to initiating an evaluation in the first place. An important aspect of our early work is to

assist staff with determining the questions that will guide the evaluation and our work with them. After describing the program, we work with the program to determine what questions will be asked of the evaluation, and then we determine what type of evaluation and design are most appropriate to answer the questions. Depending on the questions, different types of evaluations can be implemented from those that assess needs, process, outcomes, impacts, and costs. We also employ various methods that collect quantitative (e.g., surveys) and qualitative (e.g., focus groups, document review) data. We have also compared program participants to other similar individuals who have not received the program (comparison group) or examined differences in results among various groups within programs.

*Issues to Consider When Developing Evaluation Questions*:

- Are the evaluation questions appropriate for the stage or level of program development, implementation, or maturity?
- Can the evaluation questions be answered given the available evaluation resources and the timeframe allotted to complete the evaluation?
- What will be the best evaluation design to answer the questions, including evaluation type, methods, and procedures?

*Cultural Competence Considerations When Developing Evaluation Questions*:

- Do the evaluation questions involve understanding the experience of different groups participating in the program?

**Step 3: Developing the Process Evaluation.** Once the program staff and our team have reached a common understanding of the program, articulated the theory of change, developed the evaluation questions, and established a good working relationship, the next step is to develop a process evaluation. A process evaluation assesses program activities and operations (Rossi et al., 2004) and asks and answers such questions as: is the program doing what it said it would do? (e.g., are we providing the service that we said we would provide?); is the program serving the population that we said it would serve?; and, how much, what type, and how often is the program providing services? In our experience, programs have a tendency to overlook or underestimate the importance of process data; however, these data are central to detailing what a program entails, what practitioners do (Shepard, 1999), and uncovering the subtle reasons programs may or may not attain desired results (Smith, 2004). Process evaluation requires a fair amount of documentation and because of this staff tend to like this aspect of program evaluation the least. Because it is often most time-consuming and labor intensive (Dewa et al., 2001), we try to minimize additional burden by building on, strengthening, or modifying existing data collection mechanisms. We have found, however, that

if CBOs are already collecting information about consumers served and services provided, it is often in a way that is not easily quantified or aggregated. For example, information may be documented in case notes or in response to open-ended questions on program forms. The difficulty with this method is that in order to make general statements about the program, staff have to review client records and hand tally, for instance, the number of African-American families served, the types of referral sources, or the number of families served. Gathering and analyzing data in this fashion places additional demands on already limited program resources and results in staff frustration because reporting is required frequently. We address this cumbersome reporting process by developing a system in which data are more easily quantified and summarized. This system involves modifying data collection forms to identify likely response categories to questions on the forms and assigning a numerical value to each response, which can then be input into a database. We review all existing forms used to collect and document client and program information (e.g., referral, intake, discharge, treatment plan, safety plan, service utilization, and progress note forms) and funders' data reporting requirements. Having to report different data to multiple funders also frustrates staff, and to assist with this burden, we often modify forms to capture required data.

*Issues to Consider When Developing a Process Evaluation*:

- Process data can help to insure that the program is serving the population of interest and providing intended activities and services.
- There is a need to understand who is being served in order to know what questions to ask and how to ask the questions of the program and the consumers served.
- Service utilization data is important to understand dosage-response effects, that is, which types of services and how much of the services might relate to the desired results.
- Include staff in the process of modifying existing forms because they are the most knowledgeable about common consumer responses to open-ended questions, which can then be standardized on new forms.

*Cultural Competence Considerations When Developing a Process Evaluation*:

- Demographic and descriptive categories on data collection forms should accurately categorize and reflect the diversity of the community so that data and results can be examined by racial or ethnic group.

**Step 4: Developing the Outcome Evaluation.** Although programs commonly want to know if they are positively impacting consumers, staff often have difficulty identifying the outcomes they want to modify. Assessing whether actual changes have occurred in designated outcomes is even

**Table 2. Criteria for Selecting "Good" Program Outcomes**

| Criteria | Description |
|---|---|
| Measurable | Outcomes need to be quantifiable Outcomes need to be operationalized and specifically defined. |
| Realistic | Does the program have a realistic chance of changing/influencing the desired outcomes? Are the desired outcomes grounded in the research and practice literature? What does the literature say about the outcomes? Have similar programs demonstrated similar outcomes/objectives? |
| Feasible | Is collecting the outcome data doable? Test evaluation plans against real world staff constraints Can staff manage collecting and reporting the outcome data? Is the outcome data something you can actually collect (access to data sources)? |
| Useful | Will the outcome data collected be helpful? Gear evaluations toward program and institutional needs Does the data inform program and policy decisions? What does the data tell you about the program? |

more challenging. We work with staff to help shape, *not select for them,* program outcomes based on four criteria: measurable, realistic, feasible, and useful (see Table 2 for criteria for choosing outcomes that meet these criteria; also see Appendix A for outcome evaluation resources).

The development of outcomes involves integrating a program's vision of how it expects clients to benefit with our own experience in evaluating similar programs, and knowledge of research important for identifying prevention or treatment outcomes. Once outcomes are selected, we determine the indicators and the best methods to measure them. The selection of instruments is particularly important. We work in close collaboration with service providers to select evaluation tools or instruments that will best inform their work with consumers. Selecting and implementing instruments that have little or no perceived relevance to their work can result in a lack of service provider buy-in to the evaluation and can jeopardize the institutionalization of the evaluation process. If an appropriate means to assessing outcomes does not exist, we develop surveys or other such methods to meet the unique needs of programs.

*Issues to Consider When Developing an Outcome Evaluation*:

- Do the program's activities have a realistic chance of influencing the outcomes?
- Do the outcomes that are developed meet the criteria for "good" outcomes?
- How will the outcomes be measured/assessed (what indicators will be used)?
- How will the data yielded from the outcome assessment inform providers' work with consumers?

*Cultural Competence Considerations When Developing an Outcome Evaluation*:

- Select instruments that have been developed for the specific population(s) with whom the program is working (e.g., considerations of race/ethnicity, gender, age, and socioeconomic status).
- Develop and implement methods of data collection that allow participants to provide feedback in their first or preferred languages.
- Get good translations of instruments if they do not already exist. The most widely accepted procedure for translation consists of several steps. For instance, translating a survey for Spanish-speaking consumers would involve: translating it into Spanish by one translator, then having another translator translate that Spanish survey back to English, and finally comparing the two English versions. Depending on how closely the two English versions match, modification to the Spanish version may need to take place.
- Ensure that translation services are available so that families can participate in the evaluation in their native or first languages. Do not rely on family members to translate for one another, particularly do not allow children to translate for adults or parents as this interferes with hierarchies and issues of authority in families.
- Are there opportunities for consumers to rate and provide feedback specifically about the services they have received (consumer satisfaction)?
- Consider data collection methods that do not assume literacy. For example, where possible, read outcome tools aloud to consumers.
- Creation of performance indicators that incorporate need for cultural competence.

**Step 5: Data Collection and Management.** Once all process forms are developed and outcome surveys are selected, we decide with program directors and staff the best way to collect and maintain the data. Ideally, program staff collect and enter the data into existing agency MIS or databases that we have developed for the specific program. Although not always feasible, we encourage staff to collect and manage their data because it enhances their capacity to work with data and fosters ownership of the information collected and of the evaluation process itself. We also work with agency MIS staff to modify existing databases. If programs do not have an MIS we facilitate the creation of databases to serve this function.

The judgments made about a program reflect the quality of the data gathered and there are some strategies that can better ensure the collection of quality data. First, be clear about the evaluation questions you want to answer. This way you can be sure that the process and outcome evaluation tools will yield useful information. Second, include staff in the evaluation decision-making from the very beginning because this allows them a voice in developing an evaluation that is relevant to their work and important to them, thereby fostering buy-in, commitment, and ownership

of the evaluation. Third, do not recreate the wheel; use existing questionnaires/surveys or existing program forms where possible because these have already been tested with other groups and staff may already be familiar with them. Fourth, if new instruments are needed, design good questionnaires/surveys to answer the evaluation questions (see Appendix A for how to design a questionnaire that is easy to administer and answer). Fifth, minimize burden on staff for data collection by building data collection into routine program procedures and practices, such as modifying intake or discharge forms or administering outcome surveys at intake, treatment plan review, and/or discharge. Sixth, support from program directors and managers is critical and comes in many forms, such as garnering financial and human resources staff needs to participate in data collection (e.g., technology and computer programs, additional assistance of administrative staff). Seventh, training and technical assistance in this step in the evaluation is critically important. Assistance with some very practical computer-related skills such as how to use electronic mail and new computer programs is not out of the realm of what is needed. We also work with staff to learn to maintain a database, including the opportunity to simulate data entry, run reports, and practice transmitting data to us electronically. To facilitate capacity building for data collection and maintenance, we provide manuals with detailed instructions for completing forms, administering surveys, and using the database that we have developed.

*Issues to Consider in Data Collection and Management*:

- What will be the process for collecting and maintaining the process and outcome data?
- When will data collection take place? Will program staff, evaluators, or hired community members collect and enter data?
- Regular communication with the agency MIS staff is critically important to ensure the proper import, translation, and transmission of data to the evaluation team.

*Cultural Competence Issues in Data Collection and Management*:

- Are Release of Information forms that specify what information will be shared, with whom, and for what reason available in consumers' first or preferred languages?

**Step 6: Data Analysis.** We obtain program and consumer data that excludes all identifying information, and unique numbers are used to identify clients, which protects clients' confidentiality and complies with the Health Insurance Portability and Accountability Act (HIPAA). Once programs forward the data to us, either electronically or hard copies of pencil and paper forms, we review and clean the data and rectify any inconsistencies detected (e.g., request information from the CBO about clients

for whom we have service utilization data but for whom we do not have demographic data).

*Issues to Consider in Data Analysis*:

- Analyses of the data should reflect and answer evaluation questions and provide information most relevant to programs and staff.

*Cultural Competence Considerations in Data Analysis*:

- Does it make sense to examine the data by cultural groups to determine if there are differences in how consumers experience the program?

**Step 7: Data Reporting and Feedback.** We feed data back to stakeholders in many different formats, such as written reports, newsletters, and meetings with stakeholders. With respect to written reports, we typically draft reports quarterly, moving later to providing reports on an annual basis. The first series of quarterly reports are typically more detailed than those in subsequent years because they serve to present data, monitor implementation of the program and the evaluation, and address any challenges to implementing the evaluation process, such as lack of consumer agreement to participate in the evaluation, inconsistent data collection, or a large percentage of missing data. Subsequent quarterly reports focus on program monitoring. Reports always include recommendations that are derived from the data to assist staff with utilizing the findings. Draft reports are submitted for staff review in preparation for the face-to-face meeting with the evaluation team. In the meetings, the group discusses the findings and staff members have the opportunity to provide feedback and make modifications to the report. Because staff is much closer to the work than we are, we encourage them to offer their perspectives on the data, provide explanations for findings, and address any errors that they think have occurred in the analysis, reporting, or conclusions drawn from the data. These meetings also are designed to identify and address any evaluation challenges, make mid-course corrections to the process, and plan for next steps in the evaluation. Most importantly, these meetings help staff to think about how the data can inform program policies and practices. Because we maintain partnerships with funders and are contracted to conduct the evaluation and provide them with data as well, we take the responsibility for sharing final reports with them. Providing information to the funder keeps them up-to-date.

*Issues to Consider in Data Reporting and Feedback*:

- Can staff and other laypersons understand and interpret the data presented in the communication of the results? Results and analyses of the data should

be communicated in a way that practitioners and nonresearchers can understand the findings.
- Use of a variety of methods to report data back to stakeholders are needed to report data back to programs to better ensure data utilization, including written reports, newsletters, brochures, and face-to-face meetings with stakeholders.
- The inclusion of recommendations that are derived from the findings in feeding data back to programs better ensures use of the data.

*Cultural Competence Issues in Data Reporting and Feedback*:

- Are consumers provided with results?
- Are results provided in the major languages that are spoken in the community?

## Case Study

Family violence is defined as "a range of physical, sexual, and emotional maltreatment by one family member against another" (APA, 1996, p. v) and is steadily gaining national attention and concern given the associated social, economic, and health care costs. This is evidenced by the identification of *Injury and Violence Prevention* as a Focus Area of Healthy People 2010, which includes objectives to reduce maltreatment and maltreatment fatalities of children and the rate of physical assault by current or former intimate partners (US Department of Health and Human Services, 2000). Because the majority of programs to address child maltreatment and intimate partner violence have traditionally been developed and implemented through grass-roots mechanisms (Findlater & Kelly, 1999; National Council of Juvenile and Family Court Judges, 1999), the success of the national goal depends, in part, on how well these programs work to reduce the incidence (rate of new cases) and prevalence (the number of cases at any given time) of the problem. Family violence has seen tremendous growth and expansion in community-based programming over the past three decades, yet efforts to assess the effectiveness of family violence interventions work lag far behind (Gelles, 2000; Saathoff & Stoffel, 1999). This chapter supports the growing call for program evaluation in the family violence field (*The Future of Children*, 1999; Ward & Finkelhor, 2000), which is important for several reasons. First, in a review of the effectiveness of prevention and treatment interventions for women, MacMillan et al. (2001) found little evidence of effectiveness of domestic violence screening for preventing abuse, and the benefits of treatment interventions for men and women were unclear. Because there is a paucity of information on what works to address family violence (Wolfe & Jaffe, 1999) and on evidence-based family violence programs, evaluating the influence of

community-based programs on family members can inform effective programming, reduce ineffective community interventions that result in negative outcomes (Shepard, 1999), and foster community development (Burt et al., 1997) around issues of family violence. Second, the difficult economic reality facing family violence service programs necessitates continuous efforts to secure resources (Findlater & Kelly, 1999) and evaluation data can be used to communicate the positive aspects of programs to a broad array of stakeholders for sustainability. Third, given the level of distress that families experience when faced with violence in the home, it is imperative that services provided to them effectively reduce the occurrence of violence and its effects on family members' well-being. If families expend valuable resources, either voluntarily or by mandate, to prevent or address the violence, then the service community should work to ensure the provision of high-quality services. These services should also minimize the chances of negative, unintended effects. Out of respect for families, interventions must be accountable to them. Similarly, because communities of color and those affected by poverty disproportionately experience and/or are at greater risk for family violence (Benson & Fox, 2004; Cunradi et al., 2002; Family Violence Prevention Fund, 2001; Hotaling & Sugarman, 1990), programs must be accountable specifically to these groups and communities.

## *Background*

In 2001, the United States Department of Justice awarded the State of Connecticut funds to begin a new initiative in the State that focused on children exposed to domestic violence. The primary focus of this initiative was to explore, at both a grass roots/direct service level and a statewide policy level, the issue of children exposed to domestic violence. The Violence Against Women Office made funding available to the initiative for facilitation, technical assistance, and training. The Family Violence Outreach Program (FVOP) of a local domestic violence-serving agency implements the grass roots/direct service component of the initiative. The FVOP had primarily served women who were mandated to the FVOP services by the State's child protection services agency (CPS). Funding supported an extension of the FVOP services to victims with children seeking restraining orders from the civil court that had not been mandated to the FVOP services or involved with CPS. It was believed that families presenting to the civil court would represent the least severe cases of intimate partner violence and that the victims would be more motivated to participate in domestic violence services than families mandated to services. If needed services were provided early enough, the reoccurrence of violence might be reduced and families would be prevented from entering the child protection system. The funding provided for a host of support services, including parenting education about children's exposure to violence in the

home, crisis management, case management, advocacy, psychoeducation for children exposed to the violence, and mental health consultation to the FVOP staff. The location of the agency that operates the FVOP is a densely populated city of approximately 140,000 residents. The city is characterized by extreme poverty with an average per capita income of $16,306. The per capita income for the county where this town is located is $38,350, which demonstrates the relative affluence that surrounds this urban setting. In addition, less than one-third of adults hold a high school degree and only 13% a college degree. In 2000, the racial population of the city included 45% whites and 31% African Americans. Thirty-two percent of the total population identified themselves as Latino/Hispanic ethnicity (US Census Bureau, 2000).

**Step 1: Developing a Theory of Change or Logic Model.** In preparation for our first meeting with the FVOP staff, which included the FVOP coordinator, its two direct service providers, an area manager responsible for oversight of the program, and the executive director of the agency, we read the proposal that the State had submitted to the US Department of Justice. The proposal included a description of the FVOP. Based on our understanding of the proposal to the funding agency, we developed a logic model for staff review, comment, and modification (see Figure 1). The far left-hand column of the logic model is comprised of two boxes. The upper box indicates the State's goal for the FVOP as it relates to the children's exposure to domestic violence initiative: *to develop and implement a replicable model to enhance interagency collaboration to reduce the impact of witnessing domestic violence on children.* The lower box lists the resources that were available to allow the program to meet this goal. The Activities column lists all of the activities that were to be carried out by the program, including services to clients and consultation to internal staff. The original grant application proposed that the FVOP would provide mental health services to children, but after seeing these services listed in the logic model, the program decided that it lacked the staff and resources necessary to provide this service and therefore, did not provide the service. Theoretically, the FVOP activities would result in tangible products, such as the number of families served, which are listed in the Outputs column. As a result of the Activities and Outputs, it can be expected that clients will benefit in the ways that are listed in the Outcomes column. With the program staff, we routinely update and modify the logic model as the FVOP evolves.

**Step 2: Developing the Evaluation Questions.** The logic modeling process facilitated the staff talking in detail about the program and led to the generation of many potential evaluation questions. Of the potential questions, five were prioritized because they could be realistically answered given the stage of the program and the evaluation:

1. Who is the FVOP serving, i.e., what are the characteristics of families participating in the FVOP?
2. What types of services are families receiving and how long do they remain in the FVOP?
3. Is the FVOP an effective means of reaching families presenting to the civil court and to intervening before they become involved with child protection services?
4. How does domestic violence impact the children in families served?
5. How effective is the FVOP, i.e., do adults and their children demonstrate improvements as a result of participating in the program?

**Step 3: Developing the Process Evaluation.** The FVOP was responsible for reporting similar but not identical information to two funding sources for program monitoring purposes. Upon review of the program's referral form, we discovered that it did not capture all of the information needed for the funders. We also found that it consisted of numerous open-ended questions, which can be problematic because the data could not be easily aggregated and tallied. We worked with the staff to modify this form to capture required data and additional information staff deemed helpful to determine if they were effectively addressing their clients' needs (see Appendix B for the original and modified referral forms). This new version of the referral form addressed the staff's desire to better and more consistently document the following:

- information about the reported abusers;
- families' current and past CPS involvement, including the status and outcome of cases;
- services recommended or mandated by CPS to facilitate better communication sharing with CPS and other service providers to reinforce and support families in connecting to and remaining in the services;
- current services in which family members were participating to foster better communication and information sharing among service providers;
- uniform information about all children in the family, such as custody status;
- case disposition including the reasons that families might not be recommended for program participation.

Staff maintained that there were benefits to capturing some qualitative aspects of the cases, therefore, the new version allowed for some case-specific information through open-ended questions. Although longer and more detailed, the new form facilitated easier data collection, entry into a database, analysis, and reporting at the program/aggregate level.

**Step 4: Developing the Outcome Evaluation.** Not unlike other social service programs, the FVOP's previous evaluation efforts were focused on reporting outputs, such as the number of clients served or the number of units of service provided. Agency leadership expressed a strong

commitment to assessing outcomes and the assumptions and decisions made about the FVOP that had been based upon anecdotal information. We worked with staff to develop outcomes by presenting those written in the grant proposal and by asking staff to describe their thoughts about expected program accomplishments, especially how consumers would benefit or change as a result of program participation. As a result, five outcomes were selected: 1) decreased client distress, 2) decreased conflict in intimate relationships, 3) increased client social support, 4) increased positive child functioning; and 5) level of satisfaction on the part of families. Table 3 lists the five outcomes and describes the indicators (surveys) selected to assess each of them.

The selection of the indicators and surveys took several months. Initially, we had proposed that staff implement numerous surveys, but the staff let us know that it would be too burdensome to implement all of them. We held meetings with the staff to review, prioritize, and modify where necessary to make the administration more manageable. Staff administered the outcome/assessment instruments on-site upon client entry into the program, and then at 2 months following the initial assessment.

Because the FVOP focuses on the impact of intimate partner violence on the entire family, it is concerned with children's exposure to family violence and its impact on child functioning. Therefore, two unique aspects of the evaluation focused on children. First, in addition to reporting on posttraumatic stress symptoms that they might be experiencing as a result of the domestic violence (via Posttraumatic Stress Scale for Family Violence; Saunders, 1994) and relationship behaviors that they may have engaged in toward their partner or experienced by their partner (*Conflict Tactics Scale Revised*; Strauss & Hamby, 1996 and *Psychological Maltreatment of Women*; Tolman, 1999), clients were asked to select one child aged from 3 to 12 years old in the family for whom they would complete an assessment of trauma-related symptoms (*Trauma Symptom Checklist for Young Children*; Briere, 2001). Second, the evaluation assessed children's exposure to the violence in the home. With each relationship behavior the victim endorsed, they were asked if the identified child was at home. If the child was at home at the time of the behavior, the client was asked whether the child was in the same room as where the behavior occurred or in another location in the home.

After the first two years of the evaluation, we continue to modify the outcome surveys as program outcomes are modified and staff provides feedback about which surveys clients have difficulty understanding and completing due to the type of questions asked and/or the format/layout of the survey and those that are less useful to them in their work.

**Step 5: Data Collection and Management.** As mentioned previously, decisions need to be made in collaboration with staff during the outcomes development and data management steps of the evaluation. It

**Table 3. Family Violence Outreach Program Outcomes and Surveys**

| Outcome | Indicator/Survey | Indicator/Survey Description | Age Range | Spanish Available | Respondent | # Items | Admin Time | Assessment Time Frame: Baseline | Assessment Time Frame: 2 Month Follow-up |
|---|---|---|---|---|---|---|---|---|---|
| Decreased client distress (general psychological functioning, PTSD symptoms) | Posttraumatic Stress Scale for Family Violence (Saunders, 1994) | Measures posttraumatic symptoms specifically related to partner's verbal or physical abuse | Adult | No | Self-report | 17 | 5 minutes | Past 2 months | Past 2 months |
| Decreased conflict in intimate relationships | Revised Conflict Tactics Scales (CTS2) (Strauss & Hamby, 1996) | Measures psychological and physical attacks on a partner in a marital, cohabiting or dating relationship, and the use of negotiation | Adult | No | Self-report | 78 | 15 minutes | Past 2 months | Past 2 months |
| | Psychological Maltreatment of Women Inventory (PMWI) Short version (Tolman, 1999) Resource Utilization | Measures the level of psychological maltreatment of women by their male partners in an intimate relationship | Adult | No | Self-report | 14 | 5 minutes | Past 2 months | Past 2 months |

(*continued*)

**Table 3.** (*Continued*)

| Outcome | Indicator/Survey | Indicator/Survey Description | Age Range | Spanish Available | Respondent | # Items | Admin Time | Assessment Time Frame | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Baseline | 2 Month Follow-up |
| Increased client social support | Questionnaire (RUQ) (Swan, Sullivan, & Gill, 2002) | Community and social support utilization measure | Adult | Yes | Self-report interview | 35 | 10 minutes | Past 2 months | Past 2 months |
| Increased positive child functioning (only for children 3–12) | Trauma Symptom Checklist for Young Children (TSCYC) (Briere, 2001) | Caregiver report of the assessment of trauma and abuse-related symptomatology | 3–12 yrs | Yes | Parent/ caregiver | 45 | 15 minutes | Past 1 month | Past 1 month |
| Families will demonstrate satisfaction with services | The Center for Women and Families of Eastern Fairfield County, Inc. Satisfaction Measure | Self-report of satisfaction with CWF services | Adult | No | Self-report | 10 | 5 minutes | | Past 2 months |

was decided that the FVOP staff would administer the outcome surveys on-site when clients first enter services and then at 2 months following the baseline assessment. Release of information forms and most surveys to assess outcomes were provided in English and Spanish. Professionals engaged in family violence evaluation and research have written about the complexity and challenges of the work (Fontes, 2004; Sullivan, 2001; Zewig & Burt, 2002), and we faced three important questions and ethical issues as we planned for data collection. First, we had to determine if staff had the appropriate skill level to implement and interpret surveys and to utilize survey data to inform their work with clients. Ultimately, we felt that with the training that we provided on how to administer the surveys and with ongoing supervision and consultation from the FVOP coordinator and the mental health consultant, both of whom are licensed social workers, the direct service staff would have enough support to administer, interpret, and use the data from the outcome surveys to inform their day to day work with victims and their families. Second, the agency leadership was seriously concerned about maintaining outcome "assessment" data for fear that the records could be subpoenaed and used negatively against clients. The leadership decided that it would keep deidentified outcome information about clients and their children in order to protect clients from potentially negative use of the information. Third, some clients provided verbal consent to the release of information to other agencies and service providers. Some family violence researchers indicate that in order to protect clients, verbal consent should be an option that is considered (Fontes, 2004). Because our evaluation team is bound by our University's human subjects rules and regulations, we are unable to obtain information for those clients for whom only a verbal release of information was obtained. Once these ethical considerations were resolved, we coordinated with the agency's MIS staff to modify the agency's existing administrative database to capture process data that could be used to answer the evaluation questions, and we developed a database for the management of data forms and outcome surveys. The program MIS and direct service staff and our team members maintained frequent communication via email and telephone correspondence, and through face-to-face meetings at the agency. This ongoing communication facilitated the collection of data as any challenges to data collection could be addressed more immediately.

**Step 6: Data Analysis.** Due to challenges with maintaining two separate FVOP databases in which program staff stored data, we were delayed in obtaining reliable data from the program. Despite this set back, we provided the aspects of the data that were reliable to the program and state level funders, which included action steps for rectifying database challenges we were facing. We were able to obtain quality data by the end of the first year of the evaluation.

STEP 7: DATA REPORTING AND FEEDBACK. Although we had planned for quarterly reporting of the data initially, there were many problems early on with obtaining quality and reliable data from the agency's MIS. There were instances where we wrote evaluation reports but we later discovered that the data were inaccurate due to challenges with the agency's administrative MIS. Given the progression of the evaluation, results of the evaluation are generally provided annually; however, due to the need to secure additional funding to sustain the program, we have reported on other time frames at the request of the program.

Because the FVOP was participating in a time limited federally funded initiative, as per the request of the agency director, the evaluation consultant accompanied her and others from the FVOP to present the evaluation findings to current and potential funding sources.

## *Evaluation Findings*

Both process and outcome evaluation data helped to answer the evaluation questions.

1. *Who is the FVOP serving; e.g., what are the characteristics of families participating in the FVOP?* The FVOP served 123 adult victims. All of the adult clients were women, most were single, and had a mean age of 30 years. There were just about equal numbers of Caucasian/white (30%) and African-American/black clients (26%), and about 44% were of other racial backgrounds, which primarily reflected those of Hispanic/Latina ethnic origin. A large majority of these families were biological families (94.6%).

According to the clients, a majority (87.9%) of the perpetrators were male with a mean age of 32 years. Twenty-six percent of the reported perpetrators were African-American/black and 21% were Caucasian/white. Thirty-eight percent of all reported perpetrators were Latino/Hispanic. With respect to the relationship between the victims and the reported perpetrators, one-quarter were cohabiting partners of the victims, one-fifth were spouses, 15% were noncohabiting partners, about 6% were exspouses, 3% had some other relationship with the victims, and data were missing or unknown for about 28% of the perpetrators. The reported perpetrators were primarily the biological parents of the children in the home (78.3%), which showed that the assumption held by the community and CPS that men other than biological fathers perpetrated violence in the home was unfounded.

2. *What types of services are families receiving and how long do they remain in the FVOP?* The FVOP mainly provided direct (i.e., face-to-face client contact) services to clients, such as parenting-domestic violence group work with mothers. One initial program outcome set a benchmark that 70% of all families served would receive a home visit. The program provided

110 home visits to clients; however, not all clients may have desired a visit. The outcome was modified so that all families would be offered a home visit, and that visits would be made to all clients that desired one. Challenges with the agency MIS did not allow for documentation of the number of families that were offered a home visit, therefore, we were unable to accurately provide information for this outcome. The length of stay in the program was just under 2 months, which supported staff's experience that clients typically remained in service for less than 3 months, and drop out or terminate within the second month. This reinforced to the program staff that the FVOP has a relatively short window of time to provide family violence services to families and to help them get connected to other needed services.

3. *Is the FVOP an effective means to reaching families presenting to the civil court and intervening to provide needed services before they become involved with child protective services?* Data showed that most families participating in the FVOP already had involvement with child protection services (CPS). CPS provided two-thirds of the FVOP referrals and only 2% of the clients that participated in services were referred from the civil court. About 79% of families reported that they were currently involved with CPS. Of these CPS-involved families, almost 60% had a pending child maltreatment investigation, about 36% had had a substantiated abuse or neglect case, and 3% had had an unsubstantiated case. About 20% of all clients reported previous CPS involvement, two-thirds had had a substantiated case and one-third had had an unsubstantiated case. CPS had mandated or recommended about 80% of families to participate in the FVOP services. After presenting and discussing these data with the staff and agency leadership, they concluded that the program was ineffective in identifying families before they become involved with child protective services. They also concluded that their current program was not the most effective means of preventing families from entering the child protection system and are considering modifying the program to better identify non-CPS-involved families for services and focus on reducing the amount of time families remain involved with CPS.

4. *How does domestic violence impact the children served?* Upon entry into the program, clients reported that just over 40% of children were at home when victims and their partners engaged in positive communication behaviors (e.g., I showed my partner I cared even though we disagreed, my partner showed care for me even though we disagreed) to resolve conflict. With respect to negative relationship behaviors, the percentage of children that were in the home at the time of violence ranged from a high of about 40% when perpetrators engaged in psychological aggression toward clients (e.g., My partner insulted or swore at me, my partner shouted or yelled at me) to a low of about 5% in the home when the client engaged in sexually coercive behavior toward their partners (e.g., I insisted on sex when my partner did not want it). Across all types of negative relationship

behaviors, about 50% of all children that were at home were directly exposed (i.e., in the same room) to negative interadult relationship behaviors. Additionally, 69% of all children who were in the home were directly exposed to psychological abuse (e.g., I swore at my partner, my partner swore at me) that occurred between adults.

Upon entry into the program, there was a statistically significant and positive relationship between the level of caregiver and child posttraumatic stress symptoms. Although all the potential reasons for this relationship were not assessed, the finding suggested to the FVOP that continued efforts to develop interventions to reduce violence and children's exposure to violence were necessary and that a focus on the parent's symptoms might also have a positive impact on children in the home.

5. *Do adults and their children demonstrate improvement as a result of participating in the program?* Although adult clients experienced a decrease over time in the overall level of posttraumatic stress symptoms directly related to their intimate partner violence, the decrease was not statistically significant. With respect to relationship behaviors, the statistically significant results observed over time were:

- significant decrease in the percentage of clients and their partners that had engaged in at least one instance of psychologically aggressive and physically assaultive behavior toward the other;
- significant decrease in the percentage of clients experiencing physical injuries as a result of the violence;
- significant decrease in positive negotiation behaviors over time.

All of the potential reasons or explanations for these findings were not assessed by the evaluation. For instance, the significant decrease in positive negotiation behaviors to resolve conflict may be due to: increased honesty in reporting of these behaviors, initial over-reporting to avoid being seen in a negative light, realization that negotiation behaviors may not successfully decrease conflict and violence, decrease in the client taking responsibility for perpetration of violence, and thus a decrease in attempts to negotiate, or termination of the relationship.

Children's trauma-related symptoms significantly improved over time. In addition, the percentage of children directly (i.e., in the same room) exposed to violence between adults decreased over time from about 50% at baseline to less than 25% of the children at the follow up; and the percentage of children directly exposed (i.e., in the same room) when psychological abuse occurred between adults decreased over time from about 69% at baseline to about 37% at follow up. The reasons for the positive-child outcomes that were found are unclear (e.g., the perpetrator may no longer be in the home or children may have been removed from the home). The evaluation now can be directed at trying to determine which of these factors account for the observed differences.

An important focus of the evaluation is to strengthen the degree to which findings can be attributed to the FVOP and rule out alternative explanations. For instance, the evaluation questions have evolved to focus on:

- Is the program differentially effective with certain families and what characteristics of the family or situation make a difference?
- Does the amount or type of service received or length of stay in the program relate to the degree of positive changes for the clients and their children?

Over the past 2 years our experience with the FVOP has been extremely positive as agency leadership and staff have been committed to the evaluation process and have always asked questions of the data to improve their work and the well being of victims and their families. Together we have learned some valuable lessons in the conduct of culturally competent and ethical program evaluation in the domestic violence field. These lessons include:

1. *Program Evaluation is an Ongoing Process.* To be most useful, evaluation is not a one-time activity but an ongoing process. As programs evolve and develop, the program evaluation plan must be assessed and modified to reflect evaluation questions and yield data that are relevant and useful to programs/agencies (Mattessich, 2003).
2. *Hindsight is 20/20.* Additional evaluation questions will arise from the conduct of evaluation. In our case study, for instance we could not offer explanations for some of the findings (what accounted for the decrease in children's direct exposure to negative relationship behaviors) because we did not fully anticipate the most plausible explanations and, therefore, could not rule them out. The staff offered hypotheses and we are now working to modify the data collection to determine which may best explain the findings.
3. *Be Patient.* Allow sufficient time to yield consistent quality data (at least 9–12 months). We found that we underestimated the amount of time it would take to develop and implement the evaluation plan, and therefore, did not provide the program with a realistic assessment of the evaluation process. Additionally, as any aspect of the evaluation changes such as modification of forms and MIS, and staff changes, expect that these will all affect the quality and timeliness of data.
4. *Crawl Before You Walk.* Program evaluation is a developmental process, and we have learned to work with programs regardless of their stage of development and level of capacity for evaluation. We advocate that programs start where they can with evaluation. For instance, programs can work to implement process evaluations and then phase in outcome evaluations, or they can start with assessing one or two outcomes and begin to assess others once the structures and processes have been implemented with quality.

5. *Do Only What You Can Do.* Practitioners should know that there is no perfect evaluation. Evaluation plans should be balanced against real-world constraints and the costs of participating in an evaluation. Programs should take into account staff's capacity for participating in the evaluation, resources available to conduct the evaluation, as well as the cost and benefits of assessing the program.

6. *Secure a Champion.* We have found that evaluations are more successful in terms of being mainstreamed into agencies with the support and championing of agency/program leadership. If the program manager or the agency executive director indicates that evaluation is worthwhile, staff is more likely to buy in to participating. In addition, championing also comes in the form of securing resources necessary to facilitate the evaluation, such as technology support and allowances for staff training for the evaluation.

7. *Training and Technical Assistance is Crucial.* A necessary ingredient of our commitment to build the capacity of CBOs to conduct evaluation and to utilize data for continuous quality program improvement is the provision of training and technical assistance.

8. *Family Violence Program Evaluation is Filled with Complexities and Ethical Considerations.* There are many complexities and ethical considerations to take into account in planning of a program evaluation in the family violence field. We learned about many of the ethical issues from staff during the development of the evaluation plan and confronted many issues in the real world implementation of the evaluation. These ethical issues should be continually assessed. Appropriate and acceptable solutions to the ethical issues should be developed in conjunction with program staff and leadership who can provide guidance because they are experts in the family violence field and ensure that plans of action and responses to the issues are congruent with program/agency philosophies, policies, and procedures.

9. *Translation Services Can Be Expensive.* The translation of all evaluation surveys is often expensive but is required for culturally competent evaluation. The evaluation materials should be available in the languages that reflect the consumers served. Translation services can be quite expensive and considerations and adjustments need to be made for this. We have yet to have all instruments translated into Spanish due primarily to the cost associated with translation, and therefore, we have unfortunately excluded those consumers with limited English proficiency from participating in the evaluation.

10. *Develop a Strong Relationship Between Staff and Program Evaluators.* As we have referenced several times in this chapter, it is essential that the staff and evaluation team develop a mutually trusting relationship. Both parties should recognize each other's areas of expertise and work collaboratively to produce the best evaluation possible to yield quality data for program improvement and for the betterment of families.

ACKNOWLEDGMENTS: The authors gratefully acknowledge the staff and families participating in the evaluation of the Family Violence Outreach Program. This work was supported by funding from the Connecticut Department of Children and Families; U.S. Department of Justice; Grants to Encourage Arrest Policies Office; State of Connecticut Office of Policy and Management; Office of Victim Services, Connecticut Judicial Department; and Connecticut Coalition Against Domestic Violence. We would also like to thank the Investigators Group in the Division of Prevention and Community Research, Department of Psychiatry, Yale University School of Medicine for their helpful comments on an earlier draft of this paper.

## APPENDIX A. PROGRAM EVALUATION RESOURCES

*General Evaluation Resources/Developing an Evaluation*

Joint Committee on Standards for Educational Evaluation. (1994). *The program evaluation standards.* Thousand Oaks, CA: Sage. Available at http://www.eval.org/EvaluationDocuments/progeval.html

Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2004). *Evaluation: A Systematic Approach,* (7th ed.). Thousand Oaks, CA: Sage.

Smith, M. J. (2004). Process versus Outcome evaluation. In A. Roberts & K. Yeager (Eds.), *Evidence-based practice manual: Research and outcome measures in health and human services* (pp. 606–610). New York, NY: Oxford University Press.

Patton, M. Q. (1997). *Utilization-focused evaluation: The new century text* (3rd ed.). Thousand Oaks, CA: Sage.

Centers for Disease Control and Prevention. (1999). *Framework for program evaluation in public health.* MMWR 1999;48 (No. RR-11).

Copies can be purchased from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325. Telephone (202) 512-1800.

WK Kellogg Foundation. (1999). *Empowerment evaluation and foundations: A matter of perspectives.* Battle Creek, MI: WK Kellogg Foundation.

WK Kellogg Foundation. (1999). 616-968-1611, Free publication

WK Kellogg Foundation. (2003). *Guiding program direction with logic models,* http://www.wkkf.org/Pubs/Tools/Evaluation/LMDGsummary_00447_03674.pdf. Free publication

U.S. Department of Health and Human Services. (2002). *Physical activity evaluation handbook.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, http://www.cdc.gov/nccdphp/dnpa/physical/handbook/contentshtm

*General Evaluation Resources/Developing an Evaluation*

The Community Toolbox: A framework for program evaluation: A gateway to tools http://ctb.ku.edu

Bruner Foundation, http://www.brunerfoundation.org/ei/resources.htm

Shepard, M. F. (1999). Evaluating a coordinated community response. In M. F. Shepard & E. L. Pence (Eds.), Coordinating Community Responses to Domestic Violence: Lessons from Duluth and Beyond (pp. 169–191). Thousand Oaks, CA: Sage.

Outcome Evaluation

Sullivan, C. (2001). *Evaluating the Outcomes of Domestic Violence Service Programs: Some Practical Considerations and Strategies.* http://www.vawnet.org/DomesticViolence/Research/VAWnetDocs/AR-evaldv.php

How to write SMART Objectives

U.S. Department of Health and Human Services. (2002). *Physical activity evaluation handbook.* Centers for Disease Control and Prevention, 4770 Buford Highway, NE MS/K-46, Atlanta, GA 30341-3717

Telephone: (770) 488-5820, E-mail: ccdinfo@cdc.gov, Fax: (770) 488-6000

**http:/www.cdc.gov/nccdphp/dnpa/physical/handbook/appendix4. htm**

How to Design a Questionnaire That Is Easy to Administer and Answer. Linney, J. A., & Wandersman, A. (1991). Prevention Plus III: Assessing alcohol and other drug prevention programs at the school and community level: A four-step guide to assessment. Rockville, MD: US Department of Health and Human Services, Office for Substance Abuse Prevention.

Feindler, E. L., Rathus, J. H., & Silver, L. B. (2003). Assessment of family violence: A handbook for researchers and practitioners. Washington, DC: American Psychological Association.

Program Evaluation Guides

1. Mattessich, P. W. (2003). The Manager's Guide to Program Evaluation: Planning, contracting, and managing for useful results. Amherst H. Wilder Foundation. www.wilder.org/pubs.
2. Sullivan, C. (2001). Outcome Evaluation Strategies for Domestic Violence Programs: A Practical Guide. Contact: PCADV, 6400 Flank Drive, Suite 1300, Harrisburg, PA 17112-2778, 1-800-932-4632, Attn: Cindy Leedom. Cost: $25 for Domestic Violence Programs.
3. Domestic Abuse Project. (1997). Evaluating Domestic Violence Programs Manual. Minneapolis, MN: Domestic Abuse Project, Domestic

Abuse Project, 612- 874-7063 (telephone), http:/www.mndap.org/evalmanual.asp.
4. U.S. Department of Justice (2004). *A resource manual for evaluating child advocacy centers*, http:/www.ncjrs.org/pdffiles1/nij/192825.pdf
5. WK Kellogg Foundation Evaluation Handbook. (1998). The WK Kellogg Foundation: Battle Creek, MI. One Michigan Avenue East, Battle Creek, MI 49017-4058; 616-968- 1611, www.wkkf.org.
6. Administration on Children, Youth, and Families. The Program Manager's Guide to Evaluation, http:/www.acf.hhs.gov/programs/core/pubs_reports/prog_mgr.html
7. Public Health Agency of Canada. (1996). *Guide to project evaluation: A participatory approach*, http:/www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html /fvprojevaluation_e.html
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9. U.S. Department of Health and Human Services. (2002). *Physical activity evaluation handbook*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, http://www.cdc.gov/nccdphp/dnpa.
10. Agency for Healthcare Research and Quality (2002). *Evaluating Domestic Violence Programs*, http:/www.ahrq.gov/research/domesticviol/

# APPENDIX B. FVOP CASE REFERRAL

For Immediate Safety Needs
Call Hotline # 203-384-9559

Referral Date _____ Referring Police Dept. _____
Referring Agency _____ Police Incident Report # _____
DCF Worker's Name _____ Investigating Officer _____
DCF Case # _____ Officer's Phone # _____

DCF CASE NAME DOB RACE ADDRESS

DCF CASE NAME DOB RACE ADDRESS

Is it safe to call Y/N Is it safe to visit Y/N Phone #_____

REPORTED ABUSER'S NAME DOB RACE ADDRESS

RELATIONSHIP TO VICTIM RELATIONSHIP TO CHILDREN

Reason for Referral _____

Mandated Services _____

Referred Services _____

Brief Summary of Incident _____

Are there any services currently being received by anyone in the family? If yes, please include agency, name of worker, and a telephone # _____

**The Center for Women and Families of Eastern Fairfield County, Inc.**
**Family Violence Outreach Program**
**Referral Form**

Please fill out form as completely as possible. Missing/incomplete forms may delay response to your service request.

| CLIENT/VICTIM INFORMATION | REPORTED PERPETRATOR INFORMATION |
|---|---|
| NAME:_____ | NAME :_____ |
| ADDRESS:_____ | ADDRESS: _____ |
| TOWN/STATE/ZIP:_____ | TOWN/STATE/ZIP:_____ |
| TEL (H):_____(W) _____ | TEL (H):_____(W) _____ |
| CELL PHONE: _____ | CELL PHONE: _____ |
| CALL AT HOME? 1. ❑ yes 2. ❑ no CALL AT WORK? 1. ❑ yes 2. ❑ no | DOB: (MM/DD/YYYY): _____/_____/_____ AGE:_____ |
| BEST TIME TO CONTACT: 1. ❑ morning 2. ❑ afternoon 3. ❑ evening | GENDER: 1.❑ male 2.❑ female 3.❑ unknown |
| SAFE TO VISIT AT HOME?: 1. ❑ yes 2. ❑ no 3. ❑ unknown | RACIAL ORIGIN (check one): |
| DOB: (MM/DD/YYYY): _____/_____/_____ AGE:_____ | 1. ❑ White/Caucasian<br>2. ❑ Black/African-American/African<br>3. ❑ American Indian/Alaskan Native<br>4. ❑ Asian/Pacific Islander (please specify _____)<br>5. ❑ Multiracial (please specify _____)<br>15. ❑ other race (please specify _____)<br>99. ❑ unknown |
| SOCIAL SECURITY NUMBER: _____/_____/_____ | |
| GENDER: 1. ❑ male 2. ❑ female 3. ❑ unknown | |
| RACIAL ORIGIN (check one):<br>1. ❑ White/Caucasian<br>2. ❑ Black/African-American/African<br>3. ❑ American Indian/Alaskan Native (Tribe:_____)<br>4. ❑ Asian/Pacific Islander (specify _____)<br>5. ❑ Multiracial (specify _____)<br>15. ❑ other race (specify _____)<br>99. ❑ unknown | HISPANIC ORIGIN: 1. ❑ Not of Hispanic Origin<br>(check one) 2. ❑ Mexican, Mexican-American, Chicano<br>3. ❑ Puerto Rican<br>4. ❑ Cuban<br>5. ❑ other Hispanic Origin:(specify____)<br>99. ❑ unknown |
| HISPANIC ORIGIN: 1. ❑ Not of Hispanic Origin<br>check one: 2. ❑ Mexican, Mexican-American, Chicano<br>3. ❑ Puerto Rican<br>4. ❑ Cuban<br>5. ❑ other Hispanic Origin (specify _____)<br>99. ❑ unknown | RELATION OF REPORTED PERPERTATOR TO VICTIM:<br>1. ❑ spouse 5. ❑ parent 9. ❑ unknown<br>2. ❑ ex-spouse 6. ❑ sibling<br>3. ❑ partner (cohabiting) 7. ❑ aunt/uncle<br>4. ❑ partner (non-cohabiting) 8. ❑ other (please specify ) |
| MARITAL STATUS:<br>1. ❑ single 3. ❑ separated 5. ❑ widowed<br>2. ❑ married 4. ❑ divorced 6. ❑ unknown | RELATION OF REPORTED PERPETRATOR TO CHILD(REN):<br>1. ❑ biological parent<br>2. ❑ step-parent<br>3. ❑ foster parent<br>4. ❑ partner of biological parent (cohabiting)<br>5. ❑ partner of biological parent (non-cohabiting)<br>6. ❑ grandparent<br>7. ❑ aunt/uncle<br>8. ❑ other (please specify _____)<br>9. ❑ unknown<br>10. ❑ not applicable |
| PRIMARY LANGUAGE (if other than English):<br>Victim:_____Child(ren):_____<br>Is English spoken and understood? 1. ❑ yes 2. ❑ no 3. ❑ unknown<br>Is a translator needed? 1. ❑ yes 2. ❑ no 3. ❑ unknown | |

CONSENT INFORMATION: Has client signed a written release of information to CWF? 1. ❑ yes 2. ❑ no 3. ❑ unknown

Has client verbally consented to release information to CWF? 1. ❑ yes 2. ❑ no 3. ❑ unknown

**FAMILY INFORMATION**

FAMILY TYPE: 1. ❑ adoptive 4. ❑ foster
2. ❑ biological 5. ❑ relative/guardian
3. ❑ emancipated 6. ❑ other (please specify____)

HOUSEHOLD ROSTER/COMPOSITION (for household where client/victim lives most of the time, check all that apply):
1. ❑ spouse 5. ❑ father 9. ❑ uncle
2. ❑ partner 6. ❑ grandmother 10. ❑ family friend
3. ❑ child(ren) 7. ❑ grandfather 11. ❑ other (_____)
4. ❑ mother 8. ❑ aunt 12. ❑ unknown

NUMBER OF INDIVIDUALS IN HOUSEHOLD, INCLUDING CLIENT? ____
If unknown, check ❑ unknown

MONTHLY INCOME (include all income sources): $_____/MONTH

INCOME SOURCE (CHECK ALL THAT APPLY):
1. ❑ employed 4. ❑ AFDC 7. ❑ none
2. ❑ SSI 5. ❑ GA 8. ❑ other
3. ❑ partner 6. ❑ child support 9. ❑ unknown

DCF INVOLVEMENT (CURRENT): 0.no current DCF involvement
1. ❑ investigation pending
2. ❑ substantiated abuse/neglect
3. ❑ non-substantiated abuse/neglect
4. ❑ unknown

DCF CASE NAME: _____
DCF CASE NUMBER: _____
DCF WORKER: _____
TEL#:_____

DCF INVOLVEMENT (PAST): 0. ❑ no past DCF involvement
1. ❑ substantiated abuse/neglect
2. ❑ non-substantiated abuse/neglect
3. ❑ unknown

DCF CASE NAME: _____
DCF CASE NUMBER: _____
DCF WORKER: _____
TEL#:_____

**CHILD INFORMATION:** Number of Children:_____ If no children, enter "0"

| Name of Child | DOB (MM/DD/YYYY) | Age | Gender 1=M 2=F | Race 1= White 2= Black/African-American 3= American Indian/Alaskan Native 4= Asian/Pacific Islander (specify) 5= Multiracial (specify) 15= other race (specify) 99= unknown | Hispanic Origin 0= Not of Hispanic Origin 1= Mexican/Mexican American 2= Puerto Rican 3= Cuban 4= other (specify) 99= unknown | Custody Status 1= mother 2= other biological parent 3= grandparent 4= other family member 5= other (specify) 99= unknown |
|---|---|---|---|---|---|---|
| | ____/____/____ | | | | | |
| | ____/____/____ | | | | | |
| | ____/____/____ | | | | | |
| | ____/____/____ | | | | | |
| | ____/____/____ | | | | | |
| | ____/____/____ | | | | | |

**REFERRAL INFORMATION**

| PERSON REFERRING: | PHONE: |
|---|---|
| ADDRESS: | RELATIONSHIP TO VICTIM/FAMILY: |

| Referral Agency/Source of Referral: | **Town of Incident:** |
|---|---|
| 1. ❑ Center for Women and Families (Court Advocacy-Civil) | 1. ❑ Bridgeport 5. ❑ Stratford |
| 2. ❑ Center for Women and Families (Court Advocacy-Criminal) | 2. ❑ Easton 6. ❑ Trumbull |
| 3. ❑ Center for Women and Families (Domestic Violence Unit) | 3. ❑ Fairfield 7. ❑ other (please specify _____) |
| 4. ❑ Center for Women and Families (Hotline) | 4. ❑ Monore |
| 5. ❑ Center for Women and Families (Shelter) | |
| 6. ❑ Department of Children and Families | **Reason for Referral (check all that apply):** |
| 7. ❑ Department of Mental Retardation | 1. ❑ recent domestic violence incident |
| 8. ❑ other (please specify _____) | 2. ❑ domestic violence history |
| | 3. ❑ recent police involvement |
| **POLICE REPORT INCIDENT NUMBER:** _____ | 4. ❑ risk of out of home placement |
| **INVESTIGATING OFFICER:**_____ | 5. ❑ other (please specify _____) |
| **INVESTIGATING OFFICER TEL #:**_____ | |

PLEASE PROVIDE ANY ADDITIONAL INFORMATION REGARDING THE REASON FOR REFERRAL:_____

**ACCOUNT OF CURRENT ABUSIVE INCIDENT (INCIDENT PROMPTING REFERRAL)**

| Type of abuse client experienced (check all that apply): | Type of Case | Child exposure to the incident involving the victim and perpetrator (check all that apply): |
|---|---|---|
| 1. ❑ physical | 1. ❑ Civil | 1. ❑ witness (heard/saw) violent incident but was not the intended victim |
| 2. ❑ sexual | 2. ❑ Criminal | 2. ❑ physically injured and was the intended victim (intentional victim) |
| 3. ❑ emotional/psychological | 3. ❑ Family/Juvenile | 3. ❑ physically injured but someone else was the intended victim (accidental victim) |
| 4. ❑ verbal | 4. ❑ unknown | 4. ❑ other (please specify _____) |
| 5. ❑ other (please specify _____) | | 5. ❑ no apparent child exposure |
| | | 6. ❑ unknown |

BRIEF DESCRIPTION OF THE INCIDENT:_____

**SERVICES INFORMATION**

Please indicate whether the following services are DCF mandated or DCF recommended:

| | | | |
|---|---|---|---|
| Family Violence Outreach Program | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a | Anger management | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a |
| Psychiatric evaluation | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a | Parenting | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a |
| Substance abuse evaluation | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a | Other (specify): | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a |
| Substance abuse treatment | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a | Other (specify): | 1. ❑ mandated 3. ❑ unknown 2. ❑ recommended 4. ❑ n/a |

**Is anyone in the family currently receiving any of the services listed below?** 1. ❑ yes 2. ❑ no 3. ❑ unknown

| CURRENT SERVICES RECEIVED BY ANYONE IN THE FAMILY<br><br>Please check the agencies in which a family member is involved and specify the agency. | PERSON RECEIVING SERVICE<br><br>1= victim<br>2= child(ren)<br>3= perpetrator<br>4= other (specify) | SERVICE DURATION (in months) | CONTACT PERSON | PHONE # |
|---|---|---|---|---|
| ❑ Domestic Violence Related Services (shelter)<br>Agency (specify): | | | | |
| ❑ Day Treatment<br>Agency (specify): | | | | |
| ❑ Residential Treatment /Inpatient Psychiatric Hospitalization<br>Agency (specify): | | | | |
| ❑ Alcohol/Substance abuse Treatment<br>Agency (specify): | | | | |
| ❑ Outpatient Mental Health (individual assessment, individual/ family/group therapy, case management)<br>Agency (specify): | | | | |
| ❑ Other Interventions, Evaluations, or Placements<br>Agency (specify): | | | | |
| Agency (specify): | | | | |

PERSON COMPLETING FORM: _____ SIGNATURE: _____

POSITION OF PERSON COMPLETING THE FORM: _____ Phone #: _____

**FVOP USE ONLY**

Screening date: (MM/DD/YYYY)____/____/_____ Date of initial DCF contact: (MM/DD/YYYY)____/____/_____

DISPOSITION:
1. ❑ Accept for FVOP services
2. ❑ Waitlist
3. ❑ Client disinterested in services
4. ❑ Refer Out
   Referred To: _____
   Person Responsible for Referral: _____
5. ❑ Not eligible ❑ Parent Caregiver Notified? 1. ❑ yes 2. ❑ no
   ❑ Referral Source Notified? 1. ❑ yes 2. ❑ no

If client is not eligible for services, please specify reasons, check all that apply:
1. ❑ Client is primary aggressor
2. ❑ Mental health issues severe enough to interfere with services at this time
3. ❑ Substance abuse issues severe enough to interfere with services at this time
4. ❑ other (specify_____)

Comments:

Person entering data into database: _____ Date entered into database: (MM/DD/YYYY)____/____/_____

**PLEASE RETURN THIS FORM TO:**

The Center for Women and Families of Eastern Fairfield County, Inc.
Family Violence Outreach Program
203-579-8882 (fax); 203-334-6154 (phone)

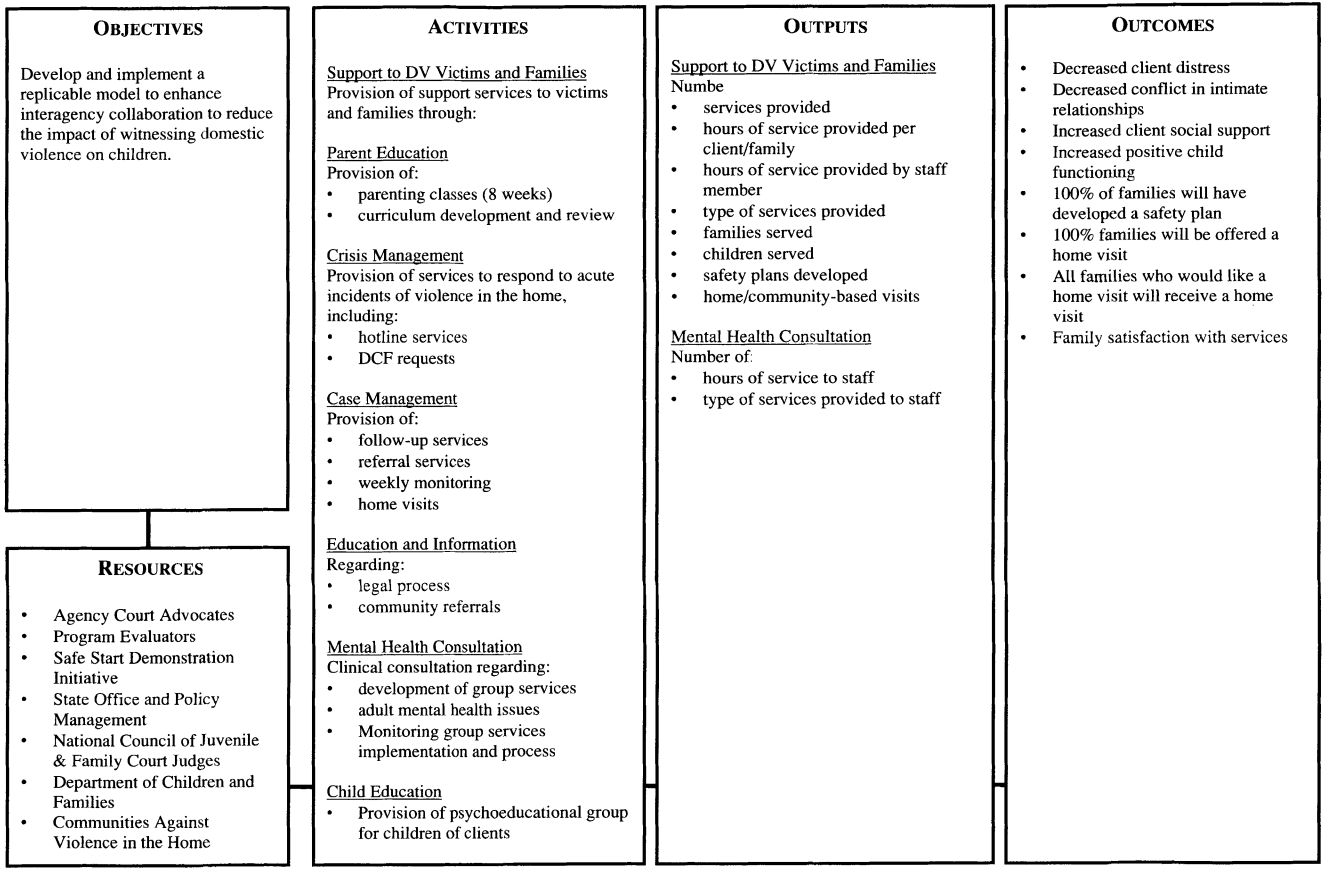


**Figure 1.** The Family Violence Outreach Program Logic Model.

## Note

1. Although the concepts presented in this chapter are applicable to all forms of family violence, our work has focused primarily on domestic violence and child maltreatment.

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