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

By: Evette Horton, Christine E. Murray, Bethany Garr, Lori Notestine, Paulina Flasch, and Catherine Higgins Johnson.

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Abstract:

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

Keywords: Safety planning | Children | Intimate partner violence | Domestic violence

Article:

1. Introduction

Intimate partner violence (IPV) describes physical, emotional, and/or sexual abuse between current or former intimate relationship partners (Murray & Graves, 2012). According to McDonald, Jouriles, Ramisetty-Mikler, Caetano, and Green (2006), 15.5 million U.S. children live in families in which IPV occurred at least one time in the past year, and seven million children live in families in which severe IPV occurred. The majority of IPV occurs within the home and children are often present in homes in which IPV occurs (Catalano, 2007). Because of

these staggering figures, researchers have increasingly studied the impact of IPV on children and effective ways to address this impact, which includes child safety planning; however, it is unclear how child safety planning is being implemented in the field. The purpose of the current study was to conduct a series of nine focus groups with domestic violence service providers to learn about their perceptions and experiences related to safety planning with children exposed to IPV.

2. **Literature Review**

2.1. Definition of child exposure to IPV

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

2.2. Impact of IPV on children

Children who are impacted by IPV face numerous safety risks. As examples, they may be placed in harm's way during a violent incident between the adults involved in the IPV, they may be left with minimal or no supervision during violent incidents and/or as a result of a parent becoming incapacitated as a result of violent victimization, they may experience mental health symptoms (e.g., anxiety and traumatic stress) as a result of witnessing violence, or they may have access to weapons used during violent episodes. In addition, children who live in homes in which parental IPV occurs also face an increased risk of being victimized themselves through child maltreatment. Kaufman Kantor and Little (2003) report that rates of overlap between child maltreatment and parental IPV may be as high as 30% to 60%. Further, children exposed to IPV are at a higher risk of being exposed to other adverse experiences of household dysfunction, such as living with a family member with a history of mental illness, substance abuse, and/or imprisonment (Lamers-Winkelman, Willemen, & Visser, 2012).

Though the impact can vary by numerous factors, such as the duration and intensity of the IPV exposure and the development stage of the child victim, it is well documented that children and adolescents are affected by the IPV between their caregivers (Child Welfare Information Gateway, 2009). In general, the younger the age of the child, the more impacted the child is likely to be (Gjelsvik et al., 2003 and Graham-Bermann and Perkins, 2010), and children under the age of six are at the greatest risk for exposure to IPV (Fantuzzo & Fusco, 2007). Graham-Bermann and Seng (2005) found that pre-schoolers who have been exposed to family violence

suffer from symptoms of post-traumatic stress disorder, such as bed-wetting or nightmares, and are at greater risk than their peers of having health related symptoms such as allergies, asthma, gastrointestinal problems, headaches, and flu. Even infants have been found to have increased stress reactivity to interparental conflict (Graham et al., 2013). Researchers have also documented prenatal influences of IPV. Whitaker, Orzol, and Kahn (2006) found that children of mothers who experience prenatal physical IPV were at an increased risk of exhibiting aggressive, anxious, depressed or hyperactive behaviors.

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

2.3. Safety planning for children impacted by IPV

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

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

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

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

creating safety plans for children (Kolar & Davey, 2007) and can practice safety strategies with their children (Kress et al., 2008 and Kress et al., 2012).

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

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

3. Methodology

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

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

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

3.1. Participants

Focus groups were conducted on-site at domestic violence agencies across central North Carolina. We invited a diverse group of domestic violence agencies to participate, including those with and without shelters, those representing urban and rural communities, standalone agencies and those connected with other services (e.g., mental health agencies), and agencies with varying amounts of resources. All nine agencies that were invited to participate did so, and participants were not compensated. Although most (n = 7) of the agencies only invited staff who worked directly in their agencies, two agencies also included affiliated professionals in their counties in the groups who were also involved in domestic violence safety planning. The final sample included 62 participants, and the average size of each group was seven participants. Participants' average age was 37.5 years (SD = 11.5), and the participants included 54 females, five males, and one participant who did not disclose his or her gender. Participants averaged 7.4 years of experience working in any job related to domestic violence. Table 1 contains a summary of participants' other key demographic data.

Table 1.
Focus group participants' demographic characteristics.

Characteristic	*n*
Ethnic background	
Caucasian	37
African American/African/Black	13
Hispanic/Latina/Latino	5
Biracial/multiracial	4
Asian/Asian American	1
Not reported	2
Highest level of completed education	
High school diploma	4
Some college	3
Associate's degree	6
Bachelor's degree	33
Master's degree	14
Doctoral degree	1
Not reported	1
Job title	
Clinical/counseling	5
Community education	2
Advocate/case manager	17
Support staff (e.g., administrative assistant)	2
Administration (e.g., executive director)	6
Program coordinator	18
Intern	6
Law enforcement	5
Not reported	1

3.2. Procedures

Each focus group was conducted by a lead facilitator and an assistant/note-taker from the Family Violence Research Group. All researchers attended a one hour training that pertained to the specific focus group questions and procedures. All focus group facilitators had a minimum of a master's degree in counseling and at least one doctoral level researcher was present at all focus groups. A semi-structured interview guide served as the basis of the focus groups, which lasted approximately 1 to 2 h each. The facilitator asked follow-up questions for clarification and to

prompt more in-depth discussion as appropriate. All focus groups were audio-recorded and later transcribed.

3.3. Coding and analysis

Stemler's (2001) outlined content analysis procedures were followed. The coding unit was defined as a participant's complete statement (i.e., beginning when a participant first spoke and ending when another person began to speak). Researchers reviewed the transcripts utilizing an emergent coding strategy. After several reviews, researchers agreed upon a final coding strategy which included five broad categories. The category under review for this article is "Safety considerations and planning for children." The other four categories address adult safety planning and are presented elsewhere (see Murray et al., in press). A pilot test of the coding system was done before the full data set was coded. To build in validity, each transcript was coded by three research team members, which allowed us to identify a consensus code for each statement. Consensus codes were either (a) a code agreed-upon by all three transcript reviewers or (b) codes rated by two out of the three transcript reviewers. When all three coders disagreed, the statement was coded as "no code." For the full data set, a total of 1863 statements were coded, resulting in a grand total of 5589 codes applied across the three raters. Also for the full data set, we calculated inter-rater reliability only for the primary codes applied to each statement. The overall percentage agreement was 82.91%. Inter-rater reliability was calculated using Fleiss' kappa, and it was found to be 0.099. We did not calculate a separate Fleiss' kappa for the subset of data relating only to children and safety planning.

4. Results

Service providers who participated in the focus groups discussed a number of issues pertaining to safety planning. The *Children and Safety Planning* primary coding category contained a total of 215 provider statements. Table 2 delineates the frequency counts in the primary and secondary codes.

Table 2.
Counts of statements falling within the primary and secondary codes.

Primary/secondary code	Number of statements coded with this code
Children and safety planning	215
Custody	45
Teen boys	34
CPS	26
No code	24
Impact	18
Involve	16
Resources	15
Parent	14
Tips	12
School	11

The *Children and Safety Planning* category contained ten secondary codes and include: (a) Child Protective Services-related issues, (b) child safety planning with the parent, (c) tools and tips for safety planning with children, (d) teen boys' needs, (e) school-related issues, (f) custody-related issues, (g) how much to involve children in safety planning, (h) resources and services for children to promote their safety and well-being, (i) the impact of parental IPV on children, and (j) no code. The *no code* (n = 24) secondary code had no consensus on the content analysis and was not analyzed in the data.

4.1. Custody (n = 45 statements)

The most frequently cited participant concern involved custody issues interfering with the safety of children and having an impact upon safety planning practices. These custody concerns included how to ensure safe exchanges of the children, how to navigate the legal system, and concern that the abuser would kidnap the children. One participant felt that visitation exchanges were a "common time for domestic violence [events] to occur." Access to legal resources for financial reasons, losing the children to the abuser because of financial instability, consulting with attorneys when moving, and other custody concerns seemed to have a significant impact on safety planning practices among participants. As one participant stated:

> I feel the waters of custody battles are so murky… It's hard for them, you know, you have to consult a lawyer every time you want to move… But the offenders kidnap the children, and basically like, we can't get them back, but you can sue for full custody… it's hard on both ends.

4.2. Special considerations with teen boys (n = 34 statements)

Another significant participant concern around safety planning with children was working with male children, particularly adolescent boys. Participants reported that many shelters do not

accept adolescent boys, and other agencies had age restrictions around accepting adolescent boys. Participants expressed that these restrictions were necessary, but also impeded services at times. Several reasons were given as a rationale around these restrictions. First, many service providers expressed concerns about possible sexual activity between adolescent male and female clients. Other participants expressed concerns that adolescent boys were more likely to be perpetrators of sexual abuse toward the children being housed in the shelter. Participants were also worried about how adolescent boys were reacting to their fathers' abusive behaviors, either through identification or rejection:

> Teenage boys began to mimic the abusive partner and start verbally abusing mom. And mom has left the relationship, she's got custody of the child, and has no control over the child because what he's observed his whole life is the man dominates the woman and his mother has been verbally abusive in front of him his whole life so he's going to mimic that behavior and act like that towards his mom. That's one side. The other side is they become the savior and try to save mom from dad and then they become an adult way too young and take the adult role of the protector. And that's not good for them either.

One specific consideration was the amount and type of space that each agency had available to them. Those participants working at shelters with multiple floors and bathrooms available to them reported that they were able to accept adolescent boys into their shelters, as opposed to smaller shelters. Participants also had to consider if teenage girls were being housed in the shelter. Participants had to also consider the age of the boys. Of those participants whose agencies addressed the needs of adolescent boys, several cut-off ages were given, ranging from 16 to 18.

For adolescent boys who were unable to stay at the shelter, several alternatives were mentioned: some participants stated that they would seek shelters that would allow the family to stay together, others stated that they would encourage families to find a friend or family member with whom the boy could stay, and one participant mentioned that her agency could fund a stay at an extended-stay hotel while searching for alternatives.

4.3. Child Protective Services (n = 26 statements)

Several issues regarding Child Protective Services (CPS) and safety planning were discussed in the context of the focus groups. One significant consideration was mandatory reporting. Several participants expressed confusion about when it was necessary to report domestic violence to CPS, particularly if children had witnessed domestic violence but had not been abused themselves. Despite this confusion, many participants emphasized the importance of mandatory reporting, and discussed how maintaining an open and positive relationship with CPS facilitated the reporting process.

A number of participants also discussed the need to reframe CPS involvement with their clients. Many participants stated that their clients viewed CPS in a negative light, and that it was important instead to help clients to understand how CPS could serve as a resource. As one participant stated:

> And that's another job that we have is to educate them that their perception of CPS is being punitive rather than support for the victim. They want the child to be safe and they want the child to be with a non-offending parent and they're going to do what they can to support that parent, given that the parent is making decisions that will keep the child safe. Part of it too, and I feel strongly that unless there's a reason not too, we usually tell somebody that we have to make the report. Just be honest to keep that relationship open. Tell them you're going to have to make this report but if it's not a punitive thing we're going to help you.

Participants expressed that their clients found it much easier to work with CPS once they realized that CPS could serve as a resource for them.

4.4. Impact (*n* = 18 statements)

The final topic that participants spoke about in relation to safety planning with children centered around the impact of IPV on children. A variety of issues were presented by participants, ranging from the effects of witnessing the violence and being pressured by the abusing parent to also being physically and sexually abused by the offending parent:

> And I think another thing, getting back to the children, is the co-occurrence that we see statistically between domestic violence, and physical abuse, and sexual abuse… There's quite a few people in the middle that experience — Families that experience both, or all three of those things.

Participants also spoke about some of the effects of witnessing the violence and the consequences of the trauma that appeared among children in the shelter. Children at different ages appear to adjust differently to shelter life, where younger children seem to adapt to communal living more quickly than older children. Furthermore, participants spoke about children witnessing violence and then siding with the abusive parent once in shelter.

4.5. Involving children in safety planning (*n* = 16 statements)

Many members of the focus groups spoke about their efforts to include children in the safety planning process. When involving children in the safety planning process, the participants noted it is important to consider how much the children knew about the violence and their ages. One participant spoke about strategically talking with children and involving them in safety planning:

> …we're trying to return the child to a normal developmental trajectory. But what normal six-year-old is having to keep herself safe? So, that's a constant push–pull. And you have to really think hard about how you frame these conversations with kids so that they're not going away more upset, more nervous, more hyper-vigilant than they were when they came in.

Participants also had a few words of caution when involving children in safety planning. Several participants noted the importance of ensuring that the responsibility for safety was not placed on

the child, but instead on the parents, as well as ensuring children were not made to feel responsible for the violence.

4.6. Resources (*n* = 15 statements)

Providing and accessing additional resources aimed at meeting the safety needs of children were topics addressed by a number of the participants. Specifically, participants spoke about making referrals to outside counselors with expertise in safety planning with children and supporting children through this process. A barrier to providing resources to children seemed to be a lack of funding and expertise available to these agencies and shelters. One participant stated:

> But at one time our agency had a child advocate which actually worked inside the shelter part-time and did just those very things, some counseling with kids, taking them to do things. Again, that sort of goes back to the whole funding issue and that kind of thing. But that's definitely something that would be beneficial to children.

A lack of funding seemed to be a primary barrier mentioned by participants to providing support groups and other resources to children in both shelters and other domestic violence agencies.

> And it goes back to when we're talking to parents, and it never fails, "He never hits me in front of the children." And so in their minds, their children aren't affected or impacted or at risk, but when you start asking them questions, or talking to them in general, "Well, let's talk about has your child's behavior changed over the past few years?" They start going, "Well, yeah." "What's going to happen if, the next time, he goes after the children?" Letting them see the impact that domestic violence has, not necessarily directly hitting the child, but children who live in these homes. And when they see that — "Oh yeah, little Sally started wetting the bed again." When you start talking to them about that, then their minds are a little more open to, "How am I going to keep my children safe? What can I do?"

Participants discussed the importance of educating clients on the many ways in which IPV can affect children, and how this educational component was a valuable part of the safety planning process.

Several participants expressed that they do not do safety planning with children directly, but instead identified ways in which they assist parents in engaging in safety planning with their children. This included education around how to discuss difficult topics such as IPV with children and how to develop a concrete safety plan with children. One participant stated:

> When talking with mom, we can help to give her ideas about how she can safety plan with her children and develop a plan with them so that if it is a code word, or where to go, kind of a fire plan type situation. So, if she has children and they are of the age where it would be age appropriate to involve them, you can give them some tools and some ideas on how to do that.

Other participants reported that they do directly engage in safety planning with children. Participants expressed the importance of doing so in an age-appropriate manner that does not overwhelm or re-traumatize the children, such as incorporating safety planning into lesson plans or creating games or quizzes around safety planning.

One final aspect of parenting that was discussed by focus groups was mothers who had not been permitted to parent their children as a result of power and control issues within the relationship. Thus, mothers were unable to control their children, and children often sided with the abusive parent; participants stated that such parents required assistance to learn how to appropriately parent children. As two service providers stated during one focus group:

> One particular mother…she'd never been really allowed to parent her children. So she had to learn parenting when she got here. Yeah. She was so into it too. I mean, she was just soaking it up, wanting as much information as possible…And that's what she was wanting. And we saw a dramatic difference.

Service providers framed education around parenting skills as a means of empowering IPV survivors.

4.8. Tips on working with children (*n* = 12 statements)

Participants also provided several specific, concrete ideas of interventions specific to children and safety planning. For example, many of the shelters had security cameras, which helped to create a sense of safety for children. Other service providers stated that helping children to identify code words they could use when they felt unsafe was a helpful, empowering intervention. Several participants stated that identifying ways to help children contact someone in an emergency was important; this included teaching children to dial 911, identifying supportive people in the child's life and storing their phone numbers in a safe place, and giving children emergency cell phones and teaching them to use them.

4.9. Interactions with schools (*n* = 11 statements)

Service providers discussed several issues involving safety planning and involvement with schools. One concern was informing school officials about issues with IPV and relocation into a shelter. This was particularly important when a family had obtained a protective order against the abusive parent:

> I talk a lot with them about making sure that daycares and schools are aware of situations, because often times they might have a protective order, someone's gonna walk right through it. Just making sure that the school or daycare, you're using your protective order to be a safety measure in safety planning, so you're letting the teachers know that you're engaging with them, because we have a lot of people that come in and say, “He's threatened to run away with the children, he's threatened to kidnap the children, he's threatened to pick the children up, it's his

> right, he's the father." Just going through some safety measures they can take within the law to do those things.

Thus, ensuring that young clients' schools are aware of protective orders and IPV was an important component of the participants' efforts to keep clients safe.

Another issue involving schools was preventative work. A number of participants stated that their agencies were involved in preventative and educational programs for students, faculty, and administration at area schools. This work ranged from informal presentations to yearly, structured, curriculum integrated into school system programming.

5. Discussion

Participants in this research study articulated the vast complexities of safety planning with children. They expressed their reservations about knowing the *right* way to do safety planning with children. Questions regarding when and how to report to CPS, when and how to include the parent in their child's safety planning, how to address the needs of adolescent boys, and at what age is it appropriate to do safety planning with children illustrate just a few of the practitioner concerns. They also expressed the difficulties of doing this type of work in the context of IPV community services, especially in the difficult fiscal environment that many programs currently face. These findings illustrate the significant challenges that arise when practitioners address the impact of IPV on children and help to promote the safety of the children and their families.

5.1. Limitations

Several limitations should be considered when interpreting the results of this study. First, the study occurred in one state, and therefore regional factors (e.g., legal requirements, cultural influences) may make the participants in this study unique from service providers in other geographic regions. Likewise, the sample should not be considered as a representative sample, as no random sampling procedures were used to recruit participants. Second, as a focus group study, the participants' responses were interdependent and may also have been impacted by subtle biases held by the research team (Piercy & Nickerson, 1996). Third, our data analyses resulted in somewhat low inter-rater agreement (Landis & Koch, 1977), and this may have been an artifact of using full participant statements as the unit of analysis, rather than using smaller coding units. Finally, because this study on children's needs and safety planning was conducted within a larger study on safety planning in general, it is possible that some aspects of safety planning that are unique to children were not addressed or were overlooked within the broader focus on general safety planning.

5.2. Implications for practice

This study provides several implications for practice. First, the practitioner participants in this study noted several familial, developmental, gender, and economic factors they felt were involved in the safety planning process for children in their agencies. The impact of safety planning on the family, the effects on the parent/child relationship for both victim and

perpetrator, and the child's developmental stage should be considered. Service providers must be cognizant of the potential distress children may have when discussing safety planning.
Many research participants mentioned custody issues arising in the context of child safety planning. Particularly, discussion and concerns around custody exchanges between survivors and perpetrators were mentioned. Therefore, service providers should assess the extent to which clients may experience safety concerns related to custody arrangements and include these concerns in their safety planning for victims and children.

In Section 4.6, participants indicated that economic factors, such as cuts in local IPV agency funding, may impact the availability of child safety planning. Collaborating and mobilizing community resources and services as part of the child safety planning process may help ensure that comprehensive support is provided, even in lean fiscal times. It is recommended that researchers and practitioners work closely to ensure that effective practice strategies for addressing client and child safety concerns are available to clients in all relevant settings. Based on our research, children's safety planning needs to be considered and addressed within a community context, as unique and often challenging circumstances can arise in multiple settings including the school, Child Protective Service agencies, and other community settings where childcare is provided and child issues are addressed. Helping communities identify and address areas of continued need and attention in order to increase viable options and resources for survivors and children of all ages is a must. For example, if IPV agencies don't have the staff to do individualized safety planning with children, referrals could be made to local mental health providers who work with infants, children, and adolescents, and can provide a thorough social–emotional assessment and interventions if needed. Many mental health interventions for these children contain a safety planning component (Cohen & Mannarino, 2008).

Second, practitioners need to consider increasing the standardization of safety planning. At the start of this article, we outlined our definition of safety planning. While participants in this study indicated they used a variety of methods and settings to conduct child safety planning, it was unclear if each and every child or adolescent that came into contact with these providers was exposed to safety planning. For example, participants noted concerns about the safety needs of teen boys, but participants did not indicate if this population systematically received safety planning.

Agencies and individual service providers vary widely in the practices they use to address the safety needs of their clients and their children, and safety planning procedures must remain flexible, ongoing, and individualized, as the needs of survivors and their children are always evolving. However, additional standardization in safety planning practices in the field will help to ensure that all child and adolescent clients entering IPV services receive more effective and equivalent services across different settings and with different service providers. One potential approach to ensuring that child safety planning is systematically explored involves adding child-specific safety questions to their current adult victim safety plans. These may include, “Have you ever talked to your child about how to stay safe?”; “Do you and your children have any safety rules?”; “Has anyone else talked to your child about how to stay safe?”; and “Is there someone your child feels comfortable talking to right now?” These questions may open the safety planning conversation with the parent and address any misconceptions the parent may have about the impact of IPV on their children/adolescents.

Agencies can also develop educational materials and forms (e.g., a brochure on child or adolescent safety or a safety planning form for children) and incorporate those materials as standard practice when working with clients when children are involved. Some of these forms can readily be found on the internet and adapted to the developmental needs of each child or adolescent. Again, if agencies are unable to provide these materials due to budgetary or personnel constraints, providers can refer all children and adolescents that come into contact with the agency to a mental health provider who can provide a safety assessment, planning, and treatment.

Research participants stressed that safety planning should be an ongoing and ever-evolving process. Promoting the safety of IPV victims and their children must remain one of the highest priorities among professionals who work with this population. Developing and advancing more effective safety planning strategies will likewise remain an important step toward achieving that goal.

5.3. Implications for future research

More research is needed to determine the extent to which safety planning actually does increase the safety of IPV victims and their children. This question becomes especially important when considering the sensitive nature of safety planning with children. Although some research indicates positive outcome trends in safety planning with children (Carter et al., 2003 and Currier and Wurtele, 1996), research on this topic remains scarce, limited, and controversial. Arguments against safety planning with children include: to what extent does involving children in safety planning make children responsible for their own safety? On the contrary, to what extent does *not* including children in safety planning and educating them on safety issues place them at risk? Given the lack of research on the effectiveness of safety planning with children, a need persists for evidence-based protocols that practitioners can use with children and their parents to enhance children's safety. Future research should focus on exploring developmentally-appropriate safety planning strategies to use with children of different ages (e.g., preschool, elementary school, adolescence) as well as their effectiveness. In addition, it is essential to examine the extent to which discussing safety in relation to parental domestic violence creates distress among children.

Future directions for research also include exploring and identifying conditions under which it is safe to involve parents in safety planning for their children. In this present study, the participants stated that some parents had misconceptions about the impact of IPV on children and adolescents. For example, the practitioner participants stated that some of the parents believed that IPV did not impact children as long as the child or adolescent had not directly witnessed the abuse. Since IPV practitioners are typically educated on the impact of IPV on children and adolescents, helping parents understand the impact IPV has on children and helping them start a dialog with their children about IPV and safety might be a first step in collaborative safety planning.

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